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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0039834

Facility Name: Jackson Sq Skl Nrsg & Living

Address: 5130 W Jackson Blvd (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: 7/1/1994

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 01/01/14 to 12/31/14 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**

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			11,650	11,650	8
9	SNF/PED					9
10	ICF	61,699	2,179	2,561	66,439	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,699	2,179	14,211	78,089	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.43%

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 7,759

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	375,550	33,703		409,253		409,253		409,253			1
2	Food Purchase		442,671		442,671	(21,681)	420,990	(124)	420,866			2
3	Housekeeping		315,951		315,951		315,951		315,951			3
4	Laundry	3,894	167,834	14,013	185,741		185,741		185,741			4
5	Heat and Other Utilities			419,202	419,202		419,202	(6,647)	412,555			5
6	Maintenance	160,564		183,278	343,842		343,842	(12,508)	331,334			6
7	Other (specify):*							441	441			7
8	TOTAL General Services	540,008	960,159	616,493	2,116,660	(21,681)	2,094,979	(18,838)	2,076,141			8
	B. Health Care and Programs											
9	Medical Director			56,260	56,260		56,260		56,260			9
10	Nursing and Medical Records	4,168,476	609,032	17,136	4,794,644		4,794,644	8,072	4,802,716			10
10a	Therapy	105,554			105,554		105,554		105,554			10a
11	Activities	134,036	7,414	650	142,100		142,100		142,100			11
12	Social Services	195,218		1,365	196,583		196,583		196,583			12
13	CNA Training											13
14	Program Transportation			29,732	29,732		29,732		29,732			14
15	Other (specify):*							1,840	1,840			15
16	TOTAL Health Care and Programs	4,603,284	616,446	105,143	5,324,873		5,324,873	9,912	5,334,785			16
	C. General Administration											
17	Administrative	170,705		1,071,638	1,242,343		1,242,343	(1,041,478)	200,865			17
18	Directors Fees											18
19	Professional Services			189,691	189,691	(1,633)	188,058	(2,628)	185,430			19
20	Dues, Fees, Subscriptions & Promotions			86,734	86,734		86,734	(64,068)	22,666			20
21	Clerical & General Office Expenses	213,704	4,811	523,784	742,299		742,299	(242,116)	500,183			21
22	Employee Benefits & Payroll Taxes			986,959	986,959	21,681	1,008,640		1,008,640			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,482	6,482		6,482	1,357	7,839			24
25	Other Admin. Staff Transportation			863	863		863	6,140	7,003			25
26	Insurance-Prop.Liab.Malpractice			1,133,739	1,133,739		1,133,739	20,148	1,153,887			26
27	Other (specify):*							21,604	21,604			27
28	TOTAL General Administration	384,409	4,811	3,999,890	4,389,110	20,048	4,409,158	(1,301,042)	3,108,117			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,527,701	1,581,416	4,721,526	11,830,643	(1,633)	11,829,010	(1,309,968)	10,519,043			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
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 Sq Skl Nrsg & Living #0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			149,430	149,430		149,430	160,126	309,556			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			88,392	88,392		88,392	366,056	454,448			32
33	Real Estate Taxes					1,633	1,633	350,870	352,502			33
34	Rent-Facility & Grounds			1,337,256	1,337,256		1,337,256	(1,336,788)	468			34
35	Rent-Equipment & Vehicles			36,206	36,206		36,206	2,877	39,083			35
36	Other (specify):*							67,572	67,572			36
37	**TOTAL Ownership**			1,611,284	1,611,284	1,633	1,612,917	(389,288)	1,223,629			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		430,179	1,604,874	2,035,053		2,035,053	(24,431)	2,010,622			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			604,860	604,860		604,860		604,860			42
43	Other (specify):*	161,109			161,109		161,109	(161,109)	0			43
44	**TOTAL Special Cost Centers**	161,109	430,179	2,209,734	2,801,022		2,801,022	(185,540)	2,615,482			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,688,810	2,011,595	8,542,544	16,242,949		16,242,949	(1,884,795)	14,358,154			45

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(9,720)	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	(131,283)	30		9
10	Interest and Other Investment Income	(303)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(124)	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	(5,188)	21		18
19	Entertainment				19
20	Contributions	(14,969)	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	(258,482)	21		24
25	Fund Raising, Advertising and Promotional	(36,524)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(340)	20		28
29	Other-Attach Schedule	(525,861)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (982,794)		$	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)	(902,001)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (902,001)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,884,795)		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

Jackson Sq Skl Nrsg & Living

ID# 0039834

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gain on Sale of Asset	$ (23,258)	30	1
2	Veterans' Expense	(11,631)	10	2
3	Rental Income	(5,150)	06	3
4	Sequestration Fee	(89,992)	21	4
5	Bank Charges	(15,133)	21	5
6	Building Co. - Professional Fees	(19,078)	19	6
7	Building Co. - Amortization	(5,109)	36	7
8	Building Co. - Licenses & Inspections	(100)	20	8
9	Annual Reports	(175)	20	9
10	PAC Dues	(13,645)	20	10
11	Guest Relation Salary	(72,882)	43	11
12	Marketing Director	(88,227)	43	12
13	Non-Allowable Fees	(7,008)	21	13
14	Non-Allowable and Out of Period Legal Fees	(11,953)	19	14
15	Medical Record Copies	(266)	10	15
16	Jury Duty Income	(34)	10	16
17	Other Unspecified Income	(54,966)	21	17
18	Additional R&M	6,080	06	18
19	Clinic Allocation - Real Estate	(28,115)	33	19
20	Clinic Allocation - Utilities	(30,711)	06	20
21	Non-Care Depreciation	(2,849)	30	21
22	Collections Expense	(51,659)	21	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(525,861)		49

Jackson Sq Skl Nrsg & Living

ID# 0039834

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(124)											(124)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,720)		3,073									(6,647)	5
6	Maintenance	(29,781)	2,752	14,521									(12,508)	6
7	Other (specify):*			441									441	7
8	**TOTAL General Services**	(39,625)	2,752	18,035									(18,838)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(11,932)		20,769			(765)						8,072	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,840									1,840	15
16	**TOTAL Health Care and Programs**	(11,932)		22,609			(765)						9,912	16
	C. General Administration													
17	Administrative			(1,041,478)									(1,041,478)	17
18	Directors Fees													18
19	Professional Services	(31,031)	19,078	9,325									(2,628)	19
20	Fees, Subscriptions & Promotions	(65,753)	100	1,585									(64,068)	20
21	Clerical & General Office Expenses	(482,428)		240,312									(242,116)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,357									1,357	24
25	Other Admin. Staff Transportation			6,140									6,140	25
26	Insurance-Prop.Liab.Malpractice		19,448	700									20,148	26
27	Other (specify):*			21,604									21,604	27
28	**TOTAL General Administration**	(579,212)	38,626	(760,456)									(1,301,042)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(630,768)	41,378	(719,812)			(765)						(1,309,968)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	(157,390)	307,163	10,353									160,126	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(303)	363,855	2,504									366,056	32
33	Real Estate Taxes	(28,115)	374,860	4,125									350,870	33
34	Rent-Facility & Grounds		(1,337,256)	468									(1,336,788)	34
35	Rent-Equipment & Vehicles			2,877									2,877	35
36	Other (specify):*	(5,109)	72,681										67,572	36
37	**TOTAL Ownership**	(190,917)	(218,697)	20,326									(389,288)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(11,676)	(12,104)	(651)						(24,431)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(161,109)											(161,109)	43
44	**TOTAL Special Cost Centers**	(161,109)			(11,676)	(12,104)	(651)						(185,540)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(982,794)	(177,319)	(699,486)	(11,676)	(12,104)	(1,416)						(1,884,795)	45

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	Rental Income	$ 1,337,256	Jackson Square Associates		$	$ (1,337,256)	1
2	V	32	Interest	563	Jackson Square Associates		364,418	363,855	2
3	V	19	Professional Fees		Jackson Square Associates		19,078	19,078	3
4	V	06	Repairs-Building		Jackson Square Associates		2,752	2,752	4
5	V	30	Depreciation		Jackson Square Associates		307,163	307,163	5
6	V	36	Amortization		Jackson Square Associates		5,109	5,109	6
7	V	33	Real Estate Taxes		Jackson Square Associates		374,860	374,860	7
8	V	26	Property & Liability Insurance		Jackson Square Associates		19,448	19,448	8
9	V	20	Licenses & Inspections		Jackson Square Associates		100	100	9
10	V	36	MIP Expense		Jackson Square Associates		67,572	67,572	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,337,819			$ 1,160,500	$ * (177,319)	14

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 3,073	$ 3,073	15
16	V	6	MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	4,981	4,981	16
17	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	9,540	9,540	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		NUCARE SERVICES CORP.	100.00%	441	441	18
19	V	10	CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	20,769	20,769	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		NUCARE SERVICES CORP.	100.00%	1,840	1,840	20
21	V	17	ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	30,160	30,160	21
22	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	9,325	9,325	22
23	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,585	1,585	23
24	V	21	CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	202,427	202,427	24
25	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	37,885	37,885	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,357	1,357	26
27	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	6,140	6,140	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	700	700	28
29	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		NUCARE SERVICES CORP.	100.00%	21,604	21,604	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	10,353	10,353	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,504	2,504	31
32	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	4,125	4,125	32
33	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	468	468	33
34	V	35	AUTO LEASE		NUCARE SERVICES CORP.	100.00%	2,877	2,877	34
35	V								35
36	V	17	BOOKKEEPING SERVICES	1,071,638	NUCARE SERVICES CORP.	100.00%		(1,071,638)	36
37	V								37
38	V								38
39	Total			$ 1,071,638			$ 372,152	$ * (699,486)	39

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	39	DME & MEDICAL SUPPLIES	$ 126,442	INTEGRA HEALTHCARE EQUIPMENT		$ 114,766	$ (11,676)	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			$ 126,442			$ 114,766	$ * (11,676)	39

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	39	RESPIRATORY SERVICES	$ 58,066	INTEGRA RESPIRATORY SERVICES LLC		$ 45,962	$ (12,104)	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			$ 58,066			$ 45,962	$ * (12,104)	39

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Ambulance	$ 3,294	Lifeline Ambulance		$ 2,529	$ (765)	15
16	V	39	Ambulance	2,802	Lifeline Ambulance		2,151	(651)	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			$ 6,096			$ 4,680	$ * (1,416)	39

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	22	WORKERS COMPENSATION	$ 113,001	MAPLELEAF INSURANCE		$ 113,001	$	15
16	V	26	LIABILITY INSURANCE	601,296	MAPLELEAF INSURANCE		601,296		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			$ 714,297			$ 714,297	$ *	39

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BARRY & RANDY CARR	4.750%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REI	CHICAGO	JACKSON SQUARE ASSOCIATE	CHICAGO	BUILDING CO.	1
2	GARY HOKIN	14.589%	CALIFORNIA GARDENS CORP.	CHICAGO	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY INS.	2
3	GERRY JENICH	5.000%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	JLR FINANCIAL SERVICES	LINCOLNWOOD	MANAGEMENT CO.	3
4	RAJCHENBACH FAMILY TRUST	4.750%	CLARIDGE IMPERIAL, LTD.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	4
5	ROBERT HARTMAN	55.750%	MONROE CORP.	CHICAGO	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	5
6	MARK HOLLANDER DISCRETIONARY TRUST	1.583%	THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	6
7	SHARON HOLLANDER DISCRETIONARY TRUST	1.583%	ARIA POST ACUTE CARE	HILLSIDE	NUCARE SERVICES	LINCOLNWOOD	BOOKEEPING	7
8	FEIGE C. KNOBEL DISCRETIONARY TRUST	1.583%	THE RENAISSANCE AT MIDWAY, INC.	CHICAGO	DRAKE LOUIS ENTERPRISE, LI	LINCOLNWOOD	MANAGEMENT CO.	8
9	DAVID HOKIN	10.411%	THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY	9
10			RENAISSANCE EAST	MESA, ARIZONA	INTEGRA HEALTHCARE EQUI	ELMHURST	DME & MEDICAL SUPPLIES	10
11			RENAISSANCE PARK SOUTH,LLC	CHICAGO	LIFELINE AMBULANCE,LLC	CHICAGO	AMBULANCE	11
12			RENAISSANCE VILLAGE AL	MESA, ARIZONA				12
13			RENAISSANCE VILLAGE IL	MESA, ARIZONA				13
14			RENAISSANCE WEST	MESA, ARIZONA				14
15			CLAREMONT - HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC.				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,239,904	17	$ 44,608	$	85,410	$ 3,073	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	72,310	72,310	85,410	4,981	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,239,904	17	138,492		85,410	9,540	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,239,904	17	6,405		85,410	441	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	301,506	301,506	85,410	20,769	5
6	15	EMPLOYEE BENEFITS - CLIN	AVAIL. CENSUS DAYS	1,239,904	17	26,708		85,410	1,840	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	437,828	437,828	85,410	30,160	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,239,904	17	135,365		85,410	9,325	8
9	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,239,904	17	23,010		85,410	1,585	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,239,904	17	2,938,655	2,938,655	85,410	202,427	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,239,904	17	549,976		85,410	37,885	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,239,904	17	19,695		85,410	1,357	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,239,904	17	89,139		85,410	6,140	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	1,239,904	17	10,164		85,410	700	14
15	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,239,904	17	313,624		85,410	21,604	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,239,904	17	150,292		85,410	10,353	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,239,904	17	36,349		85,410	2,504	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,239,904	17	59,877		85,410	4,125	18
19	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,239,904	17	6,796		85,410	468	19
20	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,239,904	17	41,766		85,410	2,877	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,402,565	$ 3,750,299		$ 372,152	25

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: Integra Healthcare Equipment, LLC
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	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	39	DME & MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 114,766	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					$	$		$ 114,766	25

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: Integra Respiratory Services LLC
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	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	39	RESPIRATORY SERVICES	DIRECT ALLOCATION			$	$		$ 45,962	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					$	$		$ 45,962	25

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: Lifeline Ambulance LLC
Street Address: 2424 S. Wabash Ave.
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	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	Ambulance	Direct Allocation			$	$		$ 2,529	1
2	39	Ambulance	Direct Allocation						2,151	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					$	$		$ 4,680	25

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: MAPLELEAF INSURANCE
Street Address: PO BOX 69,720 WEST BAY RD.
City / State / Zip Code: GRAND CAYMAN KY1-1102
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	22	WORKERS COMPENSATION	DIRECT ALLOCATION			$	$		$ 113,001	1
2	26	LIABILITY INSURANCE	DIRECT ALLOCATION						601,296	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					$	$		$ 714,297	25

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Mortgage			$	$ 12,682,195			$ 364,418	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Note Payable				2,183,047			88,392	6
7	Allocated from NuCare		X								2,504	7
8												8
9	TOTAL Facility Related						$	$ 14,865,242			$ 455,314	9
	B. Non-Facility Related*											
10	Interest Income		X								(303)	10
11	Interest Income - Bldg. Co.		X								(563)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (866)	14
15	TOTALS (line 9+line14)						$	$ 14,865,242			$ 454,448	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 67,572 **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.)**

**** 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 Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 382,979	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.)		$ 345,687	2
3. Under or (over) accrual (line 2 minus line 1).		$ (37,292)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 388,161	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.)**		$ 1,633	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** $ 4,171 **For** 2000-03 **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.		$ 352,502	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	289,566	8
	2010	304,857	9
	2011	305,520	10
	2012	333,859	11
	2013	341,563	12

2014 Accrual =$369,678 x 1.05 = $388,161

Allocated from NuCare = $4,125

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jackson Sq Skl 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-16-209-002-0000	Long Tern Care Property	$ 369,677.54	$ 341,562.54
2.	10-27-319-028-0000	Home Office Allocation	$ 89,368.57	$ 4,124.59
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 459,046.11	$ 345,687.13

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

	(A) 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			7,384	2
3	TOTALS	89,364		$ 79,003	3

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	234			1980	$ 3,173,042	$ 307,163	39	$ 81,360	$ (225,803)	$ 2,421,627	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			16,793	12
13	Various			1991	10,518		20			5,741	13
14	Various			1993	3,315		20			2,141	14
15	Various			1994	110,244		20	4,971	4,971	78,640	15
16	Various			1995	57,890		20	2,892	2,892	56,525	16
17	Various			1996	131,988		20	6,599	6,599	122,114	17
18	Various			1997	126,299		20	6,220	6,220	109,841	18
19	Various			1998	35,115		20	1,756	1,756	29,021	19
20	Various			1999	67,125		20	3,356	3,356	52,025	20
21	Various			2000	182,497		20	9,125	9,125	135,963	21
22	Various			2001	24,742		20	1,237	1,237	16,763	22
23	Various			2002	119,751		20			119,751	23
24	Various			2003	107,313		20	1,080	1,080	102,204	24
25	Various			2004	9,849		20	314	314	9,519	25
26	Various			2005	170,025		20	8,179	8,179	114,190	26
27	Various			2006	347,480		20	30,759	30,759	281,289	27
28	Various			2007	2,721		20	272	272	1,973	28
29	Various			2008	2,900		20	290	290	1,933	29
30	Various			2009	136,688		20	12,545	12,545	81,574	30
31	Various			2010	35,779		20	4,001	4,001	19,402	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 Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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
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62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		612,608			31,719	31,719	172,185	67
68	Related Party Allocations (Pages 12H & 12I)		123,462	4,996		4,778	(218)	40,716	68
69	Financial Statement Depreciation			123,322			(123,322)		69
70	TOTAL (lines 4 thru 69)		$ 5,860,312	$ 435,481		$ 211,452	$ (224,029)	$ 4,075,991	70

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	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		$ 5,860,312	$ 435,481		$ 211,452	$ (224,029)	$ 4,075,991	1
2	Remodel Bathroom, Demolish Shower, Ceiling And Remove Concr	2011	35,705		20	3,571	3,571	13,984	2
3	Replacement Project, Water Cooled Screw Chiller, Dual Screw Co	2011	174,913		20	17,491	17,491	67,050	3
4	Remove Concrete Around Drain, Install New Drain And 2" Drain	2011	24,657		20	2,466	2,466	9,452	4
5	4Th Flr Remove And Replace Existing Tub, Ceramic Tile From Fl	2011	3,880		20	388	388	1,455	5
6	1 Asst Bath 4Th Flr West- Demolish Shower Wall, Ceiling And Co	2011	17,853		20	1,785	1,785	6,695	6
7	3Rd Flr - 1 Asst Bath- Demolish Shower Wall, Ceiling, Remove Co	2011	12,473		20	1,247	1,247	4,677	7
8	2Nd Flr Remodel. Demolish Shower Wall, Ceiling, Remove Concre	2011	21,733		20	2,173	2,173	7,787	8
9	Replace Old Light Poles And Fixtures, Install New, Replace 2 Fixtu	2011	13,770		20	918	918	3,290	9
10	Swing Door Operator	2011	3,630		20	363	363	1,301	10
11	Sprinkler System Enhanement Per State Survey And Write-Up	2011	6,214		20	888	888	3,107	11
12	Repair Of Back-Up Generator, Re-Core Radiator, Replace Batteri	2011	9,256		20	926	926	3,239	12
13	Furnish & Install 2 Doors, Plain Sliced Red Oak-5Ply Fire Mineral	2011	3,227		20	323	323	1,129	13
14	Emergency Call-Replaced 10 Ft. Section Of Cracked 6" Cast Iron	2011	5,900		20	590	590	1,967	14
15	Furnish/Install 3 Sprinkler Headset The Top Of Elevater Shafts Ar	2011	4,080		20	583	583	1,894	15
16	Replacement Project, Chiller Project, Pipes	2011	9,809		20	981	981	3,433	16
17	Replaced Bearing & Installed New Hose Filters	2011	3,223		20	161	161	618	17
18	Compressor For Trane A/C	2012	3,735		20	374	374	934	18
19	Door Levers	2012	4,114		20	411	411	857	19
20	Elevator Motor	2012	2,524		20	126	126	284	20
21	Sprinkler System-Replaced 4" Check Valve	2013	2,752		20	138	138	172	21
22	Skylight Glass Replacement	2014	7,380		20	492	492	492	22
23	Parking Lot Paving	2014	13,250		20	87	87	87	23
24	Fire Alarm System	2014	9,655		20	690	690	690	24
25	Electrical Outlets In Patient Rooms	2014	5,300		20	177	177	177	25
26	Plumbing - Replace P-Trap In Boiler Room, Replace Corridor Pip	2014	20,945		20	698	698	698	26
27	Replace Door Operators On 3 Elevators	2014	36,600		20	305	305	305	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,316,888	$ 435,481		$ 249,803	$ (185,678)	$ 4,211,765	34

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,316,888	$ 435,481		$ 249,803	$ (185,678)	$ 4,211,765	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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,316,888	$ 435,481		$ 249,803	$ (185,678)	$ 4,211,765	34

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,316,888	$ 435,481		$ 249,803	$ (185,678)	$ 4,211,765	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,316,888	$ 435,481		$ 249,803	$ (185,678)	$ 4,211,765	34

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,316,888	$ 435,481		$ 249,803	$ (185,678)	$ 4,211,765	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,316,888	$ 435,481		$ 249,803	$ (185,678)	$ 4,211,765	34

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Various	2004	11,647		20	582	582	8,742	9
10	Various	2005	61,061		20	3,053	3,053	33,263	10
11									11
12									12
13	Universal Wide Style Handrail	2007	3,458		20	173	173	1,384	13
14	Furnish Hardware - Audio And Video Cable	2007	2,500		20	125	125	1,000	14
15	Duro Last Roofing System	2007	17,750		20	888	888	7,102	15
16									16
17	Fire Alram (Repair)	2007	4,364		20	218	218	1,746	17
18									18
19	Waterflow Labor/Pipe Fitting Fire Alram	2007	3,940		20	197	197	1,576	19
20	Walkway	2007	5,500		20	275	275	2,200	20
21	Renovated Parking Lot	2007	6,800		20	340	340	2,720	21
22	Fire Alarm Control Panel	2007	9,252		20	463	463	3,702	22
23									23
24	Duro Lasting Roof Work	2007	17,750		20	888	888	7,102	24
25	Bristol/Modules For Chiller	2007	5,832		20	292	292	2,334	25
26	Compresor Replacer	2007	2,823		20	141	141	1,128	26
27									27
28									28
29	Telephone System	2008	21,774		20	2,177	2,177	15,241	29
30	Digital Video Multiplexer Recorder, Color Dome Camera	2008	2,693		20	135	135	943	30
31	Elevator Car Doors	2008	3,875		20	194	194	1,357	31
32	Furnish and Install Insulated Glass Window	2008	25,820		20	1,291	1,291	9,037	32
33	Furnish and Install Solid Iron Fence	2008	4,860		20	243	243	1,701	33
34	TOTAL (lines 1 thru 33)		$ 211,699	$		$ 11,674	$ 11,674	$ 102,277	34

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 211,699	$		$ 11,674	$ 11,674	$ 102,277	1
2	Upholster Cornice & Roller Shades and Re-install	2008	27,819		20	1,391	1,391	9,737	2
3	Vinyl Floor Tile and Cove Base	2008	9,800		20	490	490	3,430	3
4									4
5	Tile work, Wallcoverings	2008	47,481		20	2,374	2,374	16,618	5
6	Renovation - Wallcoverings / Flooring / 1st & 2nd Floor	2008	29,588		20	1,479	1,479	10,355	6
7	Replacing Exit Faces and Lightbox Lexan Faces	2008	9,670		20	484	484	3,386	7
8	Capital Report Reconciliation	2008	(300)		20	(15)	(15)	(105)	8
9									9
10	K-020 IDPH Corrections-Demo & Carpentry, Painting,HVAC,								10
11	Plumbing - All Resident Rooms and Doctor Office Next Door	2012	85,025		20	4,251	4,251	12,754	11
12									12
13	Remove and Install Data Cables	2013	8,269		20	413	413	827	13
14	Remove and Installed Nre Fire Alarm Control Panel	2013	37,210		20	1,861	1,861	3,721	14
15	RECEPTACLES FOR KIOSKS	2013	4,055		20	203	203	406	15
16	SPRINKLER HEAD INSTALLATION	2013	2,850		20	143	143	285	16
17	Removed and Installed Cedar Fence on East & South Side of Build	2013	23,055		20	1,153	1,153	2,306	17
18	FIRE ALARM SYSTEM	2013	7,416		20	371	371	742	18
19									19
20	Install 15 Openings Power Outlets In 2Nd Flr Rooms For Wall Mo	2014	2,550		20	128	128	128	20
21	Replace 4 Doors With 20-Minute Fire Doors, Custom Match And S	2014	2,700		20	135	135	135	21
22	Construct Outside Patio Roof, Detach Structure From Building, B	2014	2,545		20	127	127	127	22
23	Install Alarm Bell On South Passenger Elevator; Code Data Plates,	2014	7,176		20	359	359	359	23
24	Caulking Windows	2014	22,500		20	1,125	1,125	1,125	24
25	Labor & Materials To Resurface 250 Doors, Remove Doors From I	2014	22,500		20	1,125	1,125	1,125	25
26	Roof Installation	2014	49,000		20	2,450	2,450	2,450	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 612,608	$		$ 31,719	$ 31,719	$ 172,185	34

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated- 7257 N. Lincoln	2004	66,460	1,704	20	1,899	195	21,215	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated- NuCare Services	2003	807	53	20	40	(13)	449	9
10	Allocated- NuCare Services	2004	16,381	1,072	20	820	(252)	9,347	10
11	Allocated- NuCare Services	2005	971	64	20	49	(15)	478	11
12	Allocated- NuCare Services	2006	1,317	86	20	66	(20)	551	12
13	Allocated- NuCare Services	2008	1,388	91	20	69	(22)	434	13
14	Allocated- NuCare Services	2009	22,348	1,463	20	1,117	(346)	6,268	14
15	Allocated- NuCare Services	2010	3,434	225	20	172	(53)	774	15
16	Allocated- NuCare Services	2011	186	12	20	9	(3)	36	16
17	Allocated- NuCare Services	2012	207	14	20	10	(4)	28	17
18	Allocated- NuCare Services	2014	2,583	169	20	78	(91)	78	18
19									19
20	Allocated- 7257 N. Lincoln	2005	6,059	43	20	383	340	365	20
21	Allocated- 7257 N. Lincoln	2004	1,321		20	66	66	693	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 123,462	$ 4,996		$ 4,778	$ (218)	$ 40,716	34

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 123,462	$ 4,996		$ 4,778	$ (218)	$ 40,716	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 123,462	$ 4,996		$ 4,778	$ (218)	$ 40,716	34

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 747,858	$ 4,648	$ 55,481	$ 50,833	10	$ 545,178	71
72	Current Year Purchases	45,082	670	4,071	3,401	10	4,072	72
73	Fully Depreciated Assets	1,367,542		78	78	10	1,367,540	73
74								74
75	TOTALS	$ 2,160,482	$ 5,318	$ 59,631	$ 54,313		$ 1,916,790	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1992 FORD VAN	1990	$ 2,282	$	$	$	5	$	76
77		Allocated from Nucare	2014	610	40	122	82	5	539	77
78										78
79										79
80	TOTALS			$ 2,892	$ 40	$ 122	$ 82		$ 539	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)	$ 8,559,265	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 440,839	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 309,556	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (131,283)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,129,094	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	2000 - 2002 Non-Care Assets - 2002	$ 20,903	$ 1,184	$ 16,836	86
87	Clinic Project- new cabinetry, counter top	4,400	220	1,100	87
88	Dr. Stalling's Office - Front reception new	3,700	185	740	88
89	Xray Rm: demolish 4 door opening. furni	16,700	835	3,340	89
90	Dr. Rms-Floor,Wall,Countertop,Sink,Wi	8,500	425	1,275	90
91	TOTALS	$ 54,203	$ 2,849	$ 23,291	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 Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Allocated from NuCare (Parking Lot)				468			5
6								6
7	TOTAL				$ 468 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 36,013 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	Facility		$	$ 193	17
18	Allocated from Nucare			2,877	18
19					19
20					20
21	TOTAL		$	$ 3,070	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.

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 651,738	$		$ 651,738	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			225,646			225,646	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			662,671			662,671	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				323,624		323,624	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					64,819	106,555		171,374	13
14	TOTAL			$		$ 1,604,874	$ 430,179		$ 2,035,053	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.

STATE OF ILLINOIS

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 566,957	1
2	Cash-Patient Deposits	9,187	9,187	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,066,760	5,129,707	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,704	75,531	6
7	Other Prepaid Expenses	90,918	90,918	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,226,597	$ 5,872,300	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	2,130,853	7,187,581	15
16	Equipment, at Historical Cost	1,170,949	1,991,928	16
17	Accumulated Depreciation (book methods)	(2,744,559)	(7,974,088)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		178,811	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	10,190	889,394	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 567,433	$ 6,495,821	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,794,030	$ 12,368,121	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,360,634	$ 1,360,634	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,183,047	2,183,047	29
30	Accrued Salaries Payable	122,449	122,449	30
31	Accrued Taxes Payable (excluding real estate taxes)	300,881	300,881	31
32	Accrued Real Estate Taxes(Sch.IX-B)		388,161	32
33	Accrued Interest Payable		39,912	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	363,497	363,497	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,330,508	$ 4,758,581	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,682,195	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,443,437	1,641,681	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,443,437	$ 14,323,876	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,773,945	$ 19,082,457	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 20,085	$ (6,714,336)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,794,030	$ 12,368,121	48

*(See instructions.)

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,072,129)	1
2	Restatements (describe):		2
3	**Workers Compensation**	5,052	3
4	**Rounding**	6	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,067,071)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,087,156	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)**	$ 1,087,156	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)**	$ 20,085	24 *

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,508,232	1
2	Discounts and Allowances for all Levels	(4,269,830)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,238,402	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,261,060	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,261,060	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	579,842	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	69,733	19
20	Radiology and X-Ray	8,521	20
21	Other Medical Services	89,489	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 747,585	23
	D. Non-Operating Revenue		
24	Contributions	60	24
25	Interest and Other Investment Income***	303	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 363	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	82,695	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 82,695	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,330,105	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,116,660	31
32	Health Care	5,324,873	32
33	General Administration	4,389,110	33
	B. Capital Expense		
34	Ownership	1,611,284	34
	C. Ancillary Expense		
35	Special Cost Centers	2,196,162	35
36	Provider Participation Fee	604,860	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,242,949	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,087,156	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,087,156	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,612,029	44
45	Private Pay - Net Inpatient Revenue	50,529	45
46	Medicare - Net Inpatient Revenue	980,910	46
47	Other-(specify) Managed Care	205,908	47
48	Other-(specify) Veteran	389,026	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,238,402	49

* **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.**

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

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,697	1,840	$ 97,468	$ 52.97	1
2	Assistant Director of Nursing	1,885	1,938	82,412	42.52	2
3	Registered Nurses	25,622	28,369	885,745	31.22	3
4	Licensed Practical Nurses	58,685	63,327	1,695,891	26.78	4
5	CNAs & Orderlies	118,097	130,426	1,335,163	10.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,058	6,684	105,554	15.79	8
9	Activity Director	1,764	2,117	37,327	17.63	9
10	Activity Assistants	7,991	8,930	96,709	10.83	10
11	Social Service Workers	6,297	6,621	146,927	22.19	11
12	Dietician					12
13	Food Service Supervisor	3,957	4,413	92,889	21.05	13
14	Head Cook	5,180	5,858	72,472	12.37	14
15	Cook Helpers/Assistants	18,388	20,524	210,189	10.24	15
16	Dishwashers					16
17	Maintenance Workers	8,323	9,127	160,564	17.59	17
18	Housekeepers					18
19	Laundry	371	371	3,894	10.50	19
20	Administrator	2,017	2,085	111,709	53.58	20
21	Assistant Administrator					21
22	Other Administrative	641	641	58,996	92.04	22
23	Office Manager	1,929	2,085	51,955	24.92	23
24	Clerical	8,120	8,848	161,749	18.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,000	1,126	39,538	35.11	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	11,202	11,755	241,658	20.56	33
34	TOTAL (lines 1 - 33)	289,224	317,085	$ 5,688,809 *	$ 17.94	34

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

** See instructions.

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		$		35
36	Medical Director	Monthly	56,260	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	5	283	10-03	38
39	Pharmacist Consultant	Monthly	16,853	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	650	11-03	44
45	Social Service Consultant	13 Visits	1,365	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	17	$ 75,411		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kenan R. Weekley	Administrator	0	$ 111,709
Marilyn Flaherty	VP Medicare Reimb		8,791
Sondra Mixdorf	VP Clinical		13,109
Tony Prather	Regional Dir		24,879
Michele Stuerke	VP Clinical		12,217
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 170,706

B. Administrative - Other

Description	Amount
NuCare Services - Bookkeeping Fees	$ 1,071,638
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,071,638
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 38,568
Frost, Ruttenberg & Rothblatt	Accounting	27,445
McGladrey	Accounting	648
Ability Network	Computer Services	2,746
CDW Government, Inc	Computer Services	35
Creative Technology Solutions	Computer Services	17,629
Curaspan Health Group	Computer Services	4,500
EBS Master	Computer Services	1,153
E-Health Data Solutions	Computer Services	5,112
Formation Healthcare Group	Computer Services	1,005
HDSI Health Date System	Computer Services	5,798
See Supplemental Schedule		85,053
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 189,691

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 178,256
Unemployment Compensation Insurance	117,813
FICA Taxes	408,275
Employee Health Insurance	277,083
Employee Meals	21,681
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	5,532
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,008,640

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 181)	4,322
Patient Background Checks 5	50
Dues & Subscriptions	937
Licenses & Permits	15,773
Allocated from NuCare	1,585
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,666

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,482
Allocated from NuCare	1,357
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,839

**See instructions.

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Jackson Sq Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. **ILCLTC $13645**

(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? **No**

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **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. $ **604,860**
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. $ **21,681** 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.