

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0039834</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Jackson Square Nrsg. & Rehab</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> 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.																							
Address: <u>5130 W Jackson Blvd .</u> <u>Chicago</u> <u>60644</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 921-8000</u> Fax # <u>(773) 921-3980</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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	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																								
Date of Initial License for Current Owners: <u>07/01/94</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ "Sub-S" Corp.																								
	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0039834 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>9,518</u>	<u>9,518</u>	8
9	SNF/PED					9
10	ICF	<u>54,104</u>	<u>4,213</u>	<u>1,588</u>	<u>59,905</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>54,104</u>	<u>4,213</u>	<u>11,106</u>	<u>69,423</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.28%

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 ☒

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

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

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 234 and days of care provided 8,729

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	359,326	49,836	15,258	424,420		424,420		424,420			1
2	Food Purchase		359,428		359,428	(19,633)	339,795	(218)	339,577			2
3	Housekeeping		6,657	297,832	304,489		304,489		304,489			3
4	Laundry	2,643	45,917	149,728	198,288		198,288		198,288			4
5	Heat and Other Utilities			305,061	305,061		305,061	(27,523)	277,538			5
6	Maintenance	91,396	52,554	236,122	380,072		380,072	14,703	394,775			6
7	Other (specify):*											7
8	TOTAL General Services	453,365	514,392	1,004,001	1,971,758	(19,633)	1,952,125	(13,038)	1,939,087			8
	B. Health Care and Programs											
9	Medical Director			43,500	43,500		43,500		43,500			9
10	Nursing and Medical Records	3,844,734	625,776	11,320	4,481,830		4,481,830	(3,343)	4,478,487			10
10a	Therapy			1,181	1,181		1,181		1,181			10a
11	Activities	106,779	12,541		119,320		119,320		119,320			11
12	Social Services	126,416		2,784	129,200		129,200		129,200			12
13	CNA Training											13
14	Program Transportation			3,731	3,731		3,731		3,731			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,077,929	638,317	62,516	4,778,762		4,778,762	(3,343)	4,775,419			16
	C. General Administration											
17	Administrative	167,557		829,103	996,660		996,660	(806,535)	190,125			17
18	Directors Fees											18
19	Professional Services			135,608	135,608	(4,913)	130,695	7,943	138,638			19
20	Dues, Fees, Subscriptions & Promotions			88,458	88,458		88,458	(46,675)	41,783			20
21	Clerical & General Office Expenses	273,266	21,887	236,043	531,196		531,196	902	532,098			21
22	Employee Benefits & Payroll Taxes			900,360	900,360	19,633	919,993		919,993			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,569	11,569		11,569	(3,919)	7,650			24
25	Other Admin. Staff Transportation			146	146		146	977	1,123			25
26	Insurance-Prop.Liab.Malpractice			458,424	458,424		458,424	17,893	476,317			26
27	Other (specify):*							52,174	52,174			27
28	TOTAL General Administration	440,823	21,887	2,659,711	3,122,421	14,720	3,137,141	(777,241)	2,359,901			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,972,117	1,174,596	3,726,228	9,872,941	(4,913)	9,868,028	(793,621)	9,074,407			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.

SEE ACCOUNTANTS' COMPILATION REPORT

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			171,402	171,402		171,402	132,610	304,012			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,901	49,901		49,901	617,717	667,618			32
33	Real Estate Taxes					4,913	4,913	327,431	332,344			33
34	Rent-Facility & Grounds			2,362,421	2,362,421		2,362,421	(2,361,995)	426			34
35	Rent-Equipment & Vehicles			22,816	22,816		22,816	3,338	26,154			35
36	Other (specify):*							60,083	60,083			36
37	TOTAL Ownership			2,606,540	2,606,540	4,913	2,611,453	(1,220,816)	1,390,636			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	6,062	360,053	742,538	1,108,653		1,108,653		1,108,653			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			401,587	401,587		401,587		401,587			42
43	Other (specify):*	128,152		176,583	304,735		304,735	(304,735)	(0)			43
44	TOTAL Special Cost Centers	134,214	360,053	1,320,708	1,814,975		1,814,975	(304,735)	1,510,240			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,106,331	1,534,649	7,653,476	14,294,456		14,294,456	(2,319,173)	11,975,283			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,624)	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	(128,457)	30		9
10	Interest and Other Investment Income	(57)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(218)	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	(892)	21		18
19	Entertainment	(4,422)	24		19
20	Contributions	(19,715)	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	(143,716)	21		24
25	Fund Raising, Advertising and Promotional	(22,305)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(438,033)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (765,440)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,553,733)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,553,733)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,319,173)		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

Report Period Beginning:

Ending:

ID#

0039834

01/01/11

12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Patient Needs	\$ (9,223)	10	1
2	Patient Clothing	(2,206)	10	2
3	Miscellaneous Income	(425)	21	3
4	Bank Charges	(18,016)	21	4
5	COPE Dues	(5,644)	20	5
6	Jury Duty Income	(120)	21	6
7	Discounts Earned	(70)	21	7
8	Additional R&M	8,074	06	8
9	Capitalized R&M	(3,223)	06	9
10	Web Media	(150)	43	10
11	Non-Allowable Legal	(18,390)	19	11
12	Annual Report	(175)	20	12
13	Quest Management Fee	(172,229)	43	13
14	Clinic Allocation - Real Estate	(25,893)	33	14
15	Clinic Allocation - Utilities	(22,308)	05	15
16	Non-Care Depreciation	(1,184)	30	16
17	Guest Services Staff Salary	(46,382)	43	17
18	Building Co. - Professional Fees	(11,170)	19	18
19	Building Co. - Bank Fees	(275)	21	19
20	Building Co. - Amortization	(5,965)	36	20
21	Building Co. - Licenses & Taxes	(4,174)	20	21
22	Non-Reimburseable Salary	(81,770)	43	22
23	Marketing Travel	(4,204)	43	23
24	Construction in Progress	(12,912)	21	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	(438,033)		49

ID#

0039834

Report Period Beginning:

01/01/11

Ending:

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
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93				44
94				45
95				46
96				47
97				48
98				49

Summary B

12/31/11

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(129,641)	253,465	8,660		126							132,610 30
31	Amortization of Pre-Op. & Org.												31
32	Interest	(57)	615,038	2,592		144							617,717 32
33	Real Estate Taxes	(25,893)	345,238	8,086									327,431 33
34	Rent-Facility & Grounds		(2,362,421)	426									(2,361,995) 34
35	Rent-Equipment & Vehicles			3,338									3,338 35
36	Other (specify):*	(5,965)	66,048										60,083 36
37	TOTAL Ownership	(161,556)	(1,082,632)	23,102		270							(1,220,816) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers												39
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(304,735)											(304,735) 43
44	TOTAL Special Cost Centers	(304,735)											(304,735) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(765,440)	(1,049,870)	(475,561)	7,845	(36,147)							(2,319,173) 45

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		
				Jackson Square Associates		Building Co.

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 2,362,421	Jackson Square Associates	100.00%	\$	(2,362,421)	1
2	V	32	Interest	250	Jackson Square Associates	100.00%	615,288	615,038	2
3	V	19	Professional Fees		Jackson Square Associates	100.00%	11,170	11,170	3
4	V	21	Bank Fees		Jackson Square Associates	100.00%	275	275	4
5	V	30	Depreciation		Jackson Square Associates	100.00%	253,465	253,465	5
6	V	36	Amortization		Jackson Square Associates	100.00%	5,965	5,965	6
7	V	33	Real Estate Taxes		Jackson Square Associates	100.00%	345,238	345,238	7
8	V	26	Property & Liability Insurance		Jackson Square Associates	100.00%	17,143	17,143	8
9	V	20	Misc. Licenses & Taxes		Jackson Square Associates	100.00%	4,174	4,174	9
10	V	36	MIP Expense		Jackson Square Associates	100.00%	60,083	60,083	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,362,671			\$ 1,312,801	\$ * (1,049,870)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,409	\$ 2,409	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	9,576	9,576	16
17	V	17	ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	15,092	15,092	17
18	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	26,333	26,333	18
19	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,130	1,130	19
20	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	160,325	160,325	20
21	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	288	288	21
22	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	671	671	22
23	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	750	750	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	50,780	50,780	24
25	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	8,660	8,660	25
26	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,592	2,592	26
27	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	8,086	8,086	27
28	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	426	426	28
29	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	3,338	3,338	29
30	V								30
31	V	17	MANAGEMENT FEES	766,019				(766,019)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 766,019			\$ 290,458	\$ * (475,561)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - G. JENICH		NUCARE SERVICES CORP.	100.00%	7,476	\$ 7,476	15
16	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%			16
17	V	17	ADMIN. - M. HARTMAN		NUCARE SERVICES CORP.	100.00%			17
18	V								18
19	V								19
20	V	27	EMP. BEN. - G. JENICH		NUCARE SERVICES CORP.	100.00%	369	369	20
21	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%			21
22	V	27	EMP. BEN. - M. HARTMAN		NUCARE SERVICES CORP.	100.00%			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			\$			\$ 7,845	\$ * 7,845	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MINOR EQUIPMENT	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 276	\$ 276	15
16	V	10	CLINICAL SALARIES		CLINICAL CONSULTING SERVICES, LLC	100.00%	8,086	8,086	16
17	V	19	PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%			17
18	V	20	DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	33	33	18
19	V	21	OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	15,671	15,671	19
20	V	21	OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	1,056	1,056	20
21	V	24	CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	215	215	21
22	V	25	AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	305	305	22
23	V	27	PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	81	81	23
24	V	27	OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	943	943	24
25	V	30	DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	126	126	25
26	V	32	INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	144	144	26
27	V								27
28	V	17	MANAGEMENT FEES	63,084				(63,084)	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			\$ 63,084			\$ 26,937	\$ * (36,147)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	\$ 104,795	Diamond Insurance	40.00%	\$ 104,795	\$	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			\$ 104,795			\$ 104,795	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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 & REH	CHICAGO	JACKSON SQUARE ASSOCIATE		BUILDING CO.	1
2	BERNARD HOLLANDER FAMILY TRUST	4.750%	CALIFORNIA GARDENS CORP.	CHICAGO	CLINICAL CONSULTING SERV.	LINCOLNWOOD	CLINICAL CONSULTING	2
3	GARY HOKIN	25.000%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	QUEST SERVICES CORP.	LINCOLNWOOD	MARKETING	3
4	GERRY JENICH	5.000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	DBD REHABILITAION SERV.	CHICAGO	PSYCHIATRIC SERVICES	4
5	RAJCHENBACH FAMILY TRUST	4.750%	FOREST VILLA NURSING & REHABILITATION CENTER, L.L.C.	NILES	JEM REHABILITATION SERV.	CHICAGO	PSYCHIATRIC SERVICES	5
6	ROBERT HARTMAN	55.750%	MONROE CORP.	CHICAGO	JLR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	6
7			THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	7
8			THE RENAISSANCE AT HILLSIDE, INC.	HILLSIDE	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	8
9			THE RENAISSANCE AT MIDWAY, INC.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	9
10			THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKEEPING / MANAGEMI	10
11			RENAISSANCE EAST	MESA, ARIZONA	DRAKE LOUIS ENTERPRISE, LI	LINCOLNWOOD	MANAGEMENT CO.	11
12			RENAISSANCE PARK SOUTH,LLC	CHICAGO	DIAMOND INSURANCE	NORTHBROOK	WORKERS COMP	12
13			RENAISSANCE VILLAGE AL	MESA, ARIZONA				13
14			RENAISSANCE VILLAGE IL	MESA, ARIZONA				14
15			RENAISSANCE WEST	MESA, ARIZONA				15
16			CLAREMONT - HANOVER PARK	HANOVER PARK				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Hartman	Relative	Administrative	0.00%	See Attached	0.78	1.95%		\$	17-7	1
2	Gerry Jenich	Owner	Administrative	5.00%	See Attached	1.50	3.75%	Alloc. Salary	7,476	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the										9
10	actual costs to reflect only amounts anticipated to be considered allowable by the IL Dept. of HFS.										10
11											11
12											12
13								TOTAL	\$ 7,476		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg. & Rehab # 0039834 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Ending: 12/31/11

(847) 933-2601

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg. & Rehab # 0039834 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMIN. - G. JENICH	AVG. HOURS WORKED	10	5	50,000	50,000	2	7,476	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	10	4	40,000	40,000			2
3	17	ADMIN. - M. HARTMAN	AVG. HOURS WORKED	10	1	116,135	116,135			3
4										4
5										5
6	27	EMP. BEN. - G. JENICH	AVG. HOURS WORKED	10	5	2,471		2	369	6
7	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	10	4	1,977				7
8	27	EMP. BEN. - M. HARTMAN	AVG. HOURS WORKED	10	1	5,737				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					\$ 216,319	\$ 206,135		\$ 7,845	25

Facility Name & ID Number Jackson Square Nrsg. & Rehab # 0039834 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	MINOR EQUIPMENT	AVAIL. CENSUS DAYS	1,283,340	17	\$ 4,147	\$	85,410	\$ 276	1
2	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,283,340	17	121,500	121,500	85,410	8,086	2
3	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,283,340	17			85,410		3
4	20	DUES, LICENSE & INSPECTION	AVAIL. CENSUS DAYS	1,283,340	17	500		85,410	33	4
5	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,283,340	17	235,467	235,467	85,410	15,671	5
6	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,283,340	17	15,872		85,410	1,056	6
7	24	CONTINUING EDUCATION / SY	AVAIL. CENSUS DAYS	1,283,340	17	3,225		85,410	215	7
8	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,283,340	17	4,586		85,410	305	8
9	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,283,340	17	1,222		85,410	81	9
10	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,283,340	17	14,168		85,410	943	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,283,340	17	1,896		85,410	126	11
12	32	INTEREST	AVAIL. CENSUS DAYS	1,283,340	17	2,164		85,410	144	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 404,746	\$ 356,967		\$ 26,937	25

Facility Name & ID Number Jackson Square Nrsg. & Rehab # 0039834 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Diamond Insurance
Street Address 40 Skokie Blvd, Suite 105
City / State / Zip Code Northbrook, IL 60062
Phone Number (847) 559-1002
Fax Number (847) 562-0070

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Diamond Insurance			\$	\$		\$ 104,795	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					\$	\$		\$ 104,795	25

Facility Name & ID Number Jackson Square Nrsg. & Rehab # 0039834 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab # 0039834 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab # 0039834 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab # 0039834 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab # 0039834 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	HUD Loan		X				\$	11,929,963			\$	615,288	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Shareholder Loan		X	Working Capital				1,937,319				49,900	6
7	Allocated from NuCare		X									2,592	7
8	See Supplemental Schedule											144	8
9	TOTAL Facility Related						\$	13,867,282			\$	667,924	9
	B. Non-Facility Related*												
10	Interest Income		X									(57)	10
11	Interest Income - Bldg. Co.		X									(250)	11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(307)	14
15	TOTALS (line 9+line14)						\$	13,867,282			\$	667,618	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 60,083 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Allocated from CCS		X				\$	\$			\$ 144	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										144	14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	332,799	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.)				\$	312,943	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(19,856)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	347,287	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.)				\$	4,913	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 \$ 12,147 For 06/07 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.				\$	332,343	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	250,914	8		
		2007	248,463	9		
		2008	250,726	10		
		2009	289,566	11		
		2010	304,857	12		
2011 Accrual = \$330,750 x 1.05 = \$347,287						
Allocated from NuCare = \$8,086						

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

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Jackson Square Nrsg. & Rehab</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0039834</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	(847) 236-1111	FAX #:	(847) 236-1155

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

B. Real Estate Tax Cost Allocations

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.)

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Jackson Square Nrsg. & Rehab

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0039834

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
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 ☒ NO
If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	89,364	1987	\$ 71,619	1
2	Allocation - 2757 N. Lincoln			10,116	2
3	TOTALS	89,364		\$ 81,735	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	234			1980	\$ 3,173,042	\$ 253,465	39	\$ 81,360	\$ (172,105)	\$ 2,177,547	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	482	482	5,741	13
14	Various			1993	3,315		20	166	166	1,824	14
15	Various			1994	110,244		20	5,512	5,512	62,645	15
16	Various			1995	57,890		20	2,895	2,895	47,844	16
17	Various			1996	131,988		20	6,599	6,599	102,316	17
18	Various			1997	126,299		20	6,220	6,220	91,181	18
19	Various			1998	35,115		20	1,756	1,756	23,754	19
20	Various			1999	67,125		20	3,356	3,356	41,957	20
21	Various			2000	182,497		20	9,125	9,125	108,589	21
22	Various			2001	24,742		20	1,237	1,237	13,052	22
23	Various			2002	119,751		20	11,975	11,975	114,136	23
24	Various			2003	107,313		20	9,412	9,412	87,991	24
25	Various			2004	9,849		20	918	918	7,420	25
26	Various			2005	170,025		20	10,691	10,691	87,878	26
27	Various			2006	347,480		20	31,820	31,820	187,935	27
28	Various			2007	2,721		20	272	272	1,156	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

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
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		335,757			17,877	17,877	92,068	67
68	Related Party Allocations (Pages 12H & 12I)		192,770	6,378		5,490	(888)	35,577	68
69	Financial Statement Depreciation			170,218			(170,218)		69
70	TOTAL (lines 4 thru 69)		\$ 5,477,401	\$ 430,061		\$ 207,163	\$ (222,898)	\$ 3,391,463	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0039834

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,477,401	\$ 430,061		\$ 207,163	\$ (222,898)	\$ 3,391,463	1
2	Cabinets	2008	2,900		20	290	290	1,063	2
3	60 Yds. Covering For Admin'S Office	2009	7,254		20	1,451	1,451	4,352	3
4	Conference Room Remodel	2009	3,800		20	380	380	1,077	4
5	Cables From Generator Control Panel	2009	4,976		20	498	498	1,493	5
6	Sprinklers	2009	5,385		20	359	359	898	6
7	Refacing Doors. Bannister, And Nurses Station	2009	15,610		20	1,561	1,561	3,772	7
8	25 Cubicle Curtains	2009	2,793		20	279	279	628	8
9	60 Boxes Armstrong	2009	3,098		20	310	310	697	9
10	1 Trane Compressor	2009	6,564		20	1,641	1,641	4,375	10
11	First Q Digital Reset; 1 Passive Infared Sensor Door; Plastic Bum	2009	5,912		20	591	591	1,626	11
12	29 Indoor Cameras; 3 Outdoor Cameras; 32 Dvrs	2009	18,730		20	1,873	1,873	4,526	12
13	#34672 Flooring, Walls- Bathroom	2009	33,198		20	3,320	3,320	9,129	13
14	#34954 Wall Covering/Guards	2009	2,682		20	268	268	693	14
15	#34949 1St/End Floor Wall Covering, Carpet	2009	26,686		20	2,669	2,669	6,894	15
16	Room Partitions	2010	7,000		20	1,400	1,400	2,800	16
17	Vinyl Tile- 4Th Flr Hallway, Parlor, Pantry	2010	6,124		20	408	408	749	17
18	High Tech Controller/Digital Components/Wiring On Boilers	2010	7,750		20	775	775	1,421	18
19	Vinyl Tile- 4Th Flr Hallway, Parlor, Pantry	2010	5,834		20	389	389	681	19
20	Clinic Project- New Cabinetry, Counter Tops	2010	4,400		20	880	880	1,613	20
21	1 Vulcan Hart Boiler	2010	2,842		20	406	406	710	21
22	Water Pump	2010	6,229		20	623	623	1,038	22
23	Remodel Bathroom, Demolish Shower, Ceiling And Remove Concr	2011	35,705		20	3,273	3,273	3,273	23
24	Replacement Project, Water Cooled Screw Chiller, Dual Screw Co	2011	174,913		20	14,576	14,576	14,576	24
25	Remove Concrete Around Drain, Install New Drain And 2" Drain	2011	24,657		20	2,055	2,055	2,055	25
26	4Th Flr Remove And Replace Existing Tub, Ceramic Tile From Fl	2011	3,880		20	291	291	291	26
27	1 Asst Bath 4Th Flr West- Demolish Shower Wall, Ceiling And Co	2011	17,853		20	1,339	1,339	1,339	27
28	3Rd Flr - 1 Asst Bath- Demolish Shower Wall, Ceiling, Remove Co	2011	12,473		20	935	935	935	28
29	2Nd Flr Remodel. Demolish Shower Wall, Ceiling, Remove Concr	2011	21,733		20	1,268	1,268	1,268	29
30	Replace Old Light Poles And Fixtures, Install New, Replace 2 Fixt	2011	13,770		20	536	536	536	30
31	Swing Door Operator	2011	3,630		20	212	212	212	31
32	Dr. Stalling'S Office - Front Reception New Windwos & 1 Sliding	2011	3,700		20	216	216	216	32
33	Sprinkler System Enhanement Per State Survey And Write-Up	2011	6,214		20	444	444	444	33
34	TOTAL (lines 1 thru 33)		\$ 5,975,695	\$ 430,061		\$ 252,677	\$ (177,384)	\$ 3,466,843	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,975,695	\$ 430,061		\$ 252,677	\$ (177,384)	\$ 3,466,843	1
2	Repair Of Back-Up Generator, Re-Core Radiator, Replace Batteri	2011	7,952		20	398	398	398	2
3	Furnish & Install 2 Doors, Plain Sliced Red Oak-5Ply Fire Minera	2011	3,227		20	161	161	161	3
4	Emergency Call-Replaced 10 Ft. Section Of Cracked 6" Cast Iron	2011	5,900		20	197	197	197	4
5	Xray Rm: Demolish 4 Door Opening. Furnish/Install 3 48" 90 Min	2011	16,700		20	696	696	696	5
6	Furnish/Install 3 Sprinkler Headset The Top Of Elevater Shafts A	2011	4,080		20	146	146	146	6
7	Replacement Project, Chiller Project, Pipes	2011	9,809		20	490	490	490	7
8	Replaced Bearing & Installed New Hose Filters	2011	3,223		20	161	161	161	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)		\$ 6,026,586	\$ 430,061		\$ 254,925	\$ (175,136)	\$ 3,469,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 6,026,586	\$ 430,061		\$ 254,925	\$ (175,136)	\$ 3,469,092	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)		\$ 6,026,586	\$ 430,061		\$ 254,925	\$ (175,136)	\$ 3,469,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 6,026,586	\$ 430,061		\$ 254,925	\$ (175,136)	\$ 3,469,092	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)		\$ 6,026,586	\$ 430,061		\$ 254,925	\$ (175,136)	\$ 3,469,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0039834

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								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	6,995	9
10	Various	2005	61,061		20	3,053	3,053	24,104	10
11									11
12									12
13	Universal Wide Style Handrail	2007	3,458		20	173	173	865	13
14	Furnish Hardware - Audio And Video Cable	2007	2,500		20	125	125	625	14
15	Duro Last Roofing System	2007	17,750		20	888	888	4,439	15
16									16
17	Fire Alram (Repair)	2007	4,364		20	218	218	1,091	17
18									18
19	Waterflow Labor/Pipe Fitting Fire Alram	2007	3,940		20	197	197	985	19
20	Walkway	2007	5,500		20	275	275	1,375	20
21	Renovated Parking Lot	2007	6,800		20	340	340	1,700	21
22	Fire Alarm Control Panel	2007	9,252		20	463	463	2,314	22
23									23
24	Duro Lasting Roof Work	2007	17,750		20	888	888	4,439	24
25	Bristol/Modules For Chiller	2007	5,832		20	292	292	1,459	25
26	Compresor Replacer	2007	2,823		20	141	141	705	26
27									27
28									28
29	Telephone System	2008	21,774		20	2,177	2,177	8,709	29
30	Digital Video Multiplexer Recorder, Color Dome Camera	2008	2,693		20	135	135	539	30
31	Elevator Car Doors	2008	3,875		20	194	194	776	31
32	Furnish and Install Insulated Glass Window	2008	25,820		20	1,291	1,291	5,164	32
33	Furnish and Install Solid Iron Fence	2008	4,860		20	243	243	972	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0039834

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2	Upholster Cornice & Roller Shades and Re-install	2008	27,819		20	1,391	1,391	5,564	2
3	Vinyl Floor Tile and Cove Base	2008	9,800		20	490	490	1,960	3
4									4
5									5
6									6
7	Tile work, Wallcoverings	2008	47,481		20	2,374	2,374	9,496	7
8	Renovation - Wallcoverings / Flooring / 1st & 2nd Floor	2008	29,588		20	1,479	1,479	5,917	8
9	Replacing Exit Faces and Lightbox Lexan Faces	2008	9,670		20	484	484	1,935	9
10	Capital Report Reconciliation	2008	(300)		20	(15)		(60)	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 (12F & 12G lines 1 thru 33)		\$ 335,757	\$		\$ 17,877	\$ 17,892	\$ 92,068	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0039834

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated- 7257 N. Lincoln	2004	86,253	2,212	35	2,464	252	20,023	3
4	Allocated- Clinical Consulting Services	2004	4,792	123	35	137	14	1,112	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated- 7257 N. Lincoln	2005	7,863	59	20	507	448	3,202	9
10	Allocated- 7257 N. Lincoln	2004	1,714		20	86	86	643	10
11									11
12	Allocated- Clinical Consulting Services	2005	437	3	20	28	25	178	12
13	Allocated- Clinical Consulting Services	2004	95		20	5	5	36	13
14									14
15	Allocated- NuCare Services	2003	780	34	20	39	5	319	15
16	Allocated- NuCare Services	2004	62,197	688	20	792	104	6,109	16
17	Allocated- NuCare Services	2005	938	41	20	47	6	321	17
18	Allocated- NuCare Services	2006	1,272	55	20	64	9	341	18
19	Allocated- NuCare Services	2008	1,341	58	20	67	9	218	19
20	Allocated- NuCare Services	2009	21,591	2,953	20	1,080	(1,873)	2,817	20
21	Allocated- NuCare Services	2010	3,318	144	20	166	22	250	21
22	Allocated- NuCare Services	2011	179	8	20	8		8	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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	\$764,408	\$2,133	\$46,732	\$44,599	10	\$470,858	71
72	Current Year Purchases	18,664	250	2,104	1,854	10	2,104	72
73	Fully Depreciated Assets	674,958		134	134	10	674,958	73
74								74
75	TOTALS	\$1,458,031	\$2,383	\$48,969	\$46,586		\$1,147,920	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	2010	590	26	118	92	5	167	77
78										78
79										79
80	TOTALS			\$2,872	\$26	\$118	\$92		\$167	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$7,569,224	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$432,470	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$304,013	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(128,457)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,617,178	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	INSTALL NEW COMPRESS - 2000	\$16,764	\$838	\$9,988	86
87	WATER FAUCETS - 2001	1,361	68	703	87
88	RESURFACE PK LOT/SIDEWALK - 2001	2,778	278	2,593	88
89					89
90					90
91	TOTALS	\$20,903	\$1,184	\$13,284	91

G. Construction-in-Progress

	Description	Cost	
92	Architects Fee - SAS - 2011	\$12,912	92
93			93
94			94
95		\$12,912	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.

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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 (12H & 12I lines 1 thru 33)		\$ 192,770	\$ 6,378		\$ 5,490	\$ (888)	\$ 35,577	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from NuCare (Parking Lot)				426			6
7	TOTAL				\$ 426			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease

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

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

15. Is Movable equipment rental included in building rental?
- YES
- NO
16. Rental Amount for movable equipment: \$ 26,155
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 273,519	\$		\$ 273,519	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			129,927			129,927	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			289,776			289,776	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				264,442		264,442	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			6,062		49,316	95,611		150,989	13
14	TOTAL			\$ 6,062		\$ 742,538	\$ 360,053		\$ 1,108,653	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,593	\$ 308,247	1
2	Cash-Patient Deposits	11,879	11,879	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,737,546	4,800,493	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	172,588	229,219	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	1,000,377	1,219,282	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,927,983	\$ 6,569,120	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	2,032,567	6,800,563	15
16	Equipment, at Historical Cost	1,139,948	1,821,686	16
17	Accumulated Depreciation (book methods)	(2,273,328)	(6,693,816)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		165,543	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		227,956	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 899,187	\$ 6,544,127	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,827,170	\$ 13,113,247	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,412,534	\$ 1,412,533	26
27	Officer's Accounts Payable		154,838	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,937,319	1,937,319	29
30	Accrued Salaries Payable	572,587	572,587	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,820	29,820	31
32	Accrued Real Estate Taxes(Sch.IX-B)		347,287	32
33	Accrued Interest Payable		50,901	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	20,100	20,100	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,183,726	3,183,726	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,156,086	\$ 7,709,111	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,929,963	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,929,963	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,156,086	\$ 19,639,074	46
47	TOTAL EQUITY(page 18, line 24)	\$ (328,916)	\$ (6,525,827)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,827,170	\$ 13,113,247	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (277,184)	1
2	Restatements (describe):		2
3	Late Entries - Medicare Bad Debts	(56,096)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (333,280)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,364	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)	\$ 4,364	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)	\$ (328,916)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,503,438	1
2	Discounts and Allowances for all Levels	(543,655)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,959,783	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,890,840	6
7	Oxygen	23,350	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,914,190	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	108,670	16
17	Sale of Drugs	988,486	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,607	19
20	Radiology and X-Ray	21,332	20
21	Other Medical Services	207,933	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,412,028	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	57	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 57	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	12,762	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,762	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,298,820	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,971,758	31
32	Health Care	4,778,762	32
33	General Administration	3,122,421	33
	B. Capital Expense		
34	Ownership	2,606,540	34
	C. Ancillary Expense		
35	Special Cost Centers	1,413,388	35
36	Provider Participation Fee	401,587	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,294,456	40
41	Income before Income Taxes (line 30 minus line 40)**	4,364	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,364	43

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,931	2,206	\$ 123,654	\$ 56.05	1
2	Assistant Director of Nursing	3,179	3,538	140,117	39.60	2
3	Registered Nurses	30,654	33,615	1,009,158	30.02	3
4	Licensed Practical Nurses	46,825	50,985	1,226,680	24.06	4
5	CNAs & Orderlies	106,040	117,037	1,271,000	10.86	5
6	CNA Trainees					6
7	Licensed Therapist	160	160	6,062	37.89	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,391	2,391	34,532	14.44	9
10	Activity Assistants	6,362	6,990	72,247	10.34	10
11	Social Service Workers	6,316	6,917	126,416	18.28	11
12	Dietician	3,374	3,791	77,443	20.43	12
13	Food Service Supervisor	249	280	5,721	20.43	13
14	Head Cook	5,474	6,106	70,087	11.48	14
15	Cook Helpers/Assistants	17,743	20,315	206,075	10.14	15
16	Dishwashers					16
17	Maintenance Workers	4,712	5,087	91,396	17.97	17
18	Housekeepers					18
19	Laundry	182	182	2,643	14.52	19
20	Administrator	4,144	4,523	153,035	33.83	20
21	Assistant Administrator					21
22	Other Administrative	160	160	14,522	90.76	22
23	Office Manager	1,872	2,080	55,671	26.76	23
24	Clerical	21,688	23,765	217,595	9.16	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	2,182	2,321	74,125	31.94	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,081	4,353	128,152	29.44	33
34	TOTAL (lines 1 - 33)	269,719	296,802	\$ 5,106,331 *	\$ 17.20	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	323	\$ 15,258	01-03	35
36	Medical Director	Monthly	43,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,320	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				44
45	Social Service Consultant	48	2,784	12-03	45
46	Other(specify)				46
47	Therapy	Per Visit	1,181	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	371	\$ 74,043		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberJackson Square Nrsg. & Rehab# 0039834Report Period Beginning:01/01/11Ending:12/31/11

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Farhat Sharif	Administrator	0.00%	\$ 41,784
Nikki D Dinsmore	Administrator	0.00%	39,867
Margo Marasa	Administrator	0.00%	71,383
Marilyn Flaherty	VP of MC Reimb	0.00%	14,522
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 167,556

B. Administrative - Other

Description	Amount
NuCare Services - Administrative Fees	\$ 766,019
Clinical Consulting Services - Administrative Fees	63,084
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	\$ 52,753
Frost, Ruttenberg & Rothblatt	Accounting	27,075
Personnel Planners, Inc	Unemployment Consulting	10,208
Documentation Solutions	Clinical Doc. Consultant	2,526
REAC Solutions	Compliance Inspection	2,200
CDW Government Inc	Computer Services	1,273
Emdeon	Computer Services	539
Giftrap Corporation	Computer Services	2,948
HDSI	Computer Services	3,686
MDI Achieve	Computer Services	25,046
PSD Solutions	Computer Services	7,355
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 135,608

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 104,795
Unemployment Compensation Insurance	95,262
FICA Taxes	375,647
Employee Health Insurance	240,011
Employee Meals	19,633
Illinois Municipal Retirement Fund (IMRF)*	
401 K Matching Expense	6,945
Other Employee Benefits	22,683
Vision & Dental Insurance	10,743
Pension Expense	37,172
Chicago Head Tax	7,104
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,327
Advertising: Employee Recruitment	6,133
Health Care Worker Background Check (Indicate # of checks performed 576)	5,881
Patient Background Checks	
Advertising & Promotions	22,305
Licenses & Inspections	10,711
Dues & Subscriptions	16,568
Allocated from NuCare	1,130
See Supplemental Schedule	33
Less: Public Relations Expense	()
Non-allowable advertising	(22,305)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	7,147
Allocated from NuCare	288
Allocated from CCS	215
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,650

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$22,675 ; IL Assoc. of HC \$5,676

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 862 Line 10

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 401,587
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. \$ 19,633 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 out of Schedule V? Yes

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

SEE ACCOUNTANTS' COMPILATION REPORT