

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0039834

Facility Name: Jackson Square Nsg & Rehab Ctr

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

County: Cook

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

HFS ID Number: 363961688001

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Richard S. Sgarlata, 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834 Report Period Beginning: 01/01/06 Ending: 12/31/06

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>67,340</u>	<u>380</u>	<u>8,083</u>	<u>75,803</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>67,340</u>	<u>380</u>	<u>8,083</u>	<u>75,803</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.75%

D. How many bed-hold days during this year were paid by the Department?

43 (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 07/01/94

J. Was the facility purchased or leased after January 1, 1978?

YES Date 07/01/94 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 66 and days of care provided 7,364

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	309,944	87,113	12,749	409,806		409,806		409,806		1
2	Food Purchase		339,586		339,586	(17,104)	322,482	(17)	322,465		2
3	Housekeeping		49,745	374,963	424,708		424,708		424,708		3
4	Laundry		23,777		23,777		23,777		23,777		4
5	Heat and Other Utilities			277,819	277,819		277,819	(18,292)	259,527		5
6	Maintenance	82,989	51,155	176,059	310,203		310,203	(4,371)	305,832		6
7	Other (specify):*										7
8	TOTAL General Services	392,933	551,376	841,590	1,785,899	(17,104)	1,768,795	(22,680)	1,746,115		8
	B. Health Care and Programs										
9	Medical Director			41,500	41,500		41,500		41,500		9
10	Nursing and Medical Records	3,164,425	240,582	132,364	3,537,371		3,537,371	(12,832)	3,524,539		10
10a	Therapy			3,157	3,157		3,157		3,157		10a
11	Activities	91,380	10,453	943	102,776		102,776		102,776		11
12	Social Services	130,289		2,098	132,387		132,387		132,387		12
13	CNA Training										13
14	Program Transportation			4,284	4,284		4,284		4,284		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,386,094	251,035	184,346	3,821,475		3,821,475	(12,832)	3,808,643		16
	C. General Administration										
17	Administrative	118,914		787,838	906,752		906,752	(753,218)	153,534		17
18	Directors Fees										18
19	Professional Services			99,204	99,204	(1,571)	97,633	(4,461)	93,172		19
20	Dues, Fees, Subscriptions & Promotions			107,442	107,442		107,442	(55,942)	51,500		20
21	Clerical & General Office Expenses	210,766	44,186	197,410	452,362		452,362	22,340	474,702		21
22	Employee Benefits & Payroll Taxes			696,985	696,985	17,104	714,089		714,089		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,447	13,447		13,447	387	13,834		24
25	Other Admin. Staff Transportation			945	945		945	443	1,388		25
26	Insurance-Prop.Liab.Malpractice			228,066	228,066		228,066	13,825	241,891		26
27	Other (specify):*							31,322	31,322		27
28	TOTAL General Administration	329,680	44,186	2,131,337	2,505,203	15,533	2,520,736	(745,304)	1,775,432		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,108,707	846,597	3,157,273	8,112,577	(1,571)	8,111,006	(780,816)	7,330,190		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr #0039834 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			215,855	215,855		215,855	140,777	356,632			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			79,541	79,541		79,541	662,788	742,329			32
33	Real Estate Taxes					1,571	1,571	285,448	287,019			33
34	Rent-Facility & Grounds			1,826,520	1,826,520		1,826,520	(1,825,997)	523			34
35	Rent-Equipment & Vehicles			8,584	8,584		8,584	3,325	11,909			35
36	Other (specify):*							70,226	70,226			36
37	TOTAL Ownership			2,130,500	2,130,500	1,571	2,132,071	(663,433)	1,468,638			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,642	754,894	803,536		803,536		803,536			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,115	128,115		128,115		128,115			42
43	Other (specify):*	110,171			110,171		110,171	(110,171)				43
44	TOTAL Special Cost Centers	110,171	48,642	883,009	1,041,822		1,041,822	(110,171)	931,651			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,218,878	895,239	6,170,782	11,284,899	0	11,284,899	(1,554,420)	9,730,479			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO, PLEASE CORRECT

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning: 01/01/06

Ending: 12/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(76,020)	30		9
10	Interest and Other Investment Income	(96)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	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	(4,228)	20		18
19	Entertainment	(1,767)	24		19
20	Contributions	(14,940)	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	(96,000)	21		24
25	Fund Raising, Advertising and Promotional	(35,167)	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	(246,279)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (474,514)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,079,906)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,079,906)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,554,420)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1		1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
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92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101		101
Total	(246,279)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(17)											(17)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(20,836)		2,544									(18,292)	5
6	Maintenance	(9,014)		4,643									(4,371)	6
7	Other (specify):*													7
8	TOTAL General Services	(29,867)		7,187									(22,680)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12,832)											(12,832)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(12,832)											(12,832)	16
	C. General Administration													
17	Administrative			(753,218)									(753,218)	17
18	Directors Fees													18
19	Professional Services	(10,485)		6,024									(4,461)	19
20	Fees, Subscriptions & Promotions	(57,835)		1,893									(55,942)	20
21	Clerical & General Office Expenses	(152,772)		175,112									22,340	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,767)		2,154									387	24
25	Other Admin. Staff Transportation			443									443	25
26	Insurance-Prop.Liab.Malpractice		12,204	1,621									13,825	26
27	Other (specify):*			31,322									31,322	27
28	TOTAL General Administration	(222,859)	12,204	(534,649)									(745,304)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(265,558)	12,204	(527,462)									(780,816)	29

STATE OF ILLINOIS

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(76,020)	202,928	13,869									140,777	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(96)	655,576	7,308									662,788	32
33	Real Estate Taxes	(22,669)	302,248	5,869									285,448	33
34	Rent-Facility & Grounds		(1,826,520)	523									(1,825,997)	34
35	Rent-Equipment & Vehicles			3,325									3,325	35
36	Other (specify):*		70,226										70,226	36
37	TOTAL Ownership	(98,785)	(595,542)	30,894									(663,433)	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):*	(110,171)											(110,171)	43
44	TOTAL Special Cost Centers	(110,171)											(110,171)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(474,514)	(583,338)	(496,568)									(1,554,420)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				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 Rent	\$ 1,826,520	Jackson Square Associates	100.00%	\$	\$ (1,826,520)	1
2	V	32 Interest	2,479	Jackson Square Associates	100.00%		(2,479)	2
3	V	30 Depreciation		Jackson Square Associates	100.00%	202,928	202,928	3
4	V	36 Amortization		Jackson Square Associates	100.00%	5,965	5,965	4
5	V	33 Real Estate Taxes		Jackson Square Associates	100.00%	302,248	302,248	5
6	V	26 Property & Liability Insurance		Jackson Square Associates	100.00%	12,204	12,204	6
7	V	32 Interest - HUD Loan		Jackson Square Associates	100.00%	658,055	658,055	7
8	V	36 MIP Expense		Jackson Square Associates	100.00%	64,261	64,261	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,828,999			\$ 1,245,661	\$ * (583,338)	14

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

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning: 01/01/06

Ending: 12/31/06

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%	\$ 2,544	2,544	15
16	V	6 REPAIRS AND MAINT.				4,643	4,643	16
17	V	17 ADMINISTRATIVE - NON-OWNER				21,170	21,170	17
18	V	19 PROFESSIONAL FEES				6,024	6,024	18
19	V	20 FEES SUBSCRIPTIONS				1,893	1,893	19
20	V	21 CLERICAL & GENERAL				175,112	175,112	20
21	V	24 SEMINARS AND EDUCATION				2,154	2,154	21
22	V	25 ADMIN. STAFF TRAVEL				443	443	22
23	V	26 INSURANCE				1,621	1,621	23
24	V	27 EMPLOYEE BEN. GEN. ADMIN.				27,914	27,914	24
25	V	30 DEPRECIATION				13,869	13,869	25
26	V	32 INTEREST EXPENSE				7,308	7,308	26
27	V	33 REAL ESTATE TAX				5,869	5,869	27
28	V	34 BUILDING RENT				523	523	28
29	V	35 EQUIPMENT RENTAL				3,325	3,325	29
30	V	17 ADMIN. - R. HARTMAN				4,736	4,736	30
31	V	17 ADMIN. - B. CARR				8,714	8,714	31
32	V	17 ADMIN. - D. HARTMAN						32
33	V	27 EMP. BEN. - R. HARTMAN				2,729	2,729	33
34	V	27 EMP. BEN. - B. CARR				679	679	34
35	V	27 EMP. BEN. - D. HARTMAN						35
36	V							36
37	V	17 MANAGEMENT FEES	787,838				(787,838)	37
38	V							38
39	Total		\$ 787,838			\$ 291,270	\$ * (496,568)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Workmans Compensation	61,327	Diamond Insurance	40.00%	61,327		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			\$ 61,327			\$ 61,327	\$ *	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.

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.

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.

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Robert Hartman	Owner	Administrative	57.48%	See Attached	0.95	1.90%	Allocation	\$ 4,736	17-7	1
2	Barry Carr	Owner	Administrative	4.75%	See Attached	4.74	9.48%	Allocation	8,714	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,450		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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS 901,760	11	\$ 26,855	\$	85,410	\$ 2,544	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 901,760	11	49,026		85,410	4,643	2
3	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS 901,760	11	223,510	216,927	85,410	21,170	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 901,760	11	63,602		85,410	6,024	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 901,760	11	19,990		85,410	1,893	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 901,760	11	1,848,833	1,578,326	85,410	175,112	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 901,760	11	22,739		85,410	2,154	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 901,760	11	4,678		85,410	443	8
9	26	INSURANCE	AVAIL. CENSUS DAYS 901,760	11	17,114		85,410	1,621	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS 901,760	11	294,714		85,410	27,914	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS 901,760	11	146,433		85,410	13,869	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 901,760	11	77,159		85,410	7,308	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 901,760	11	61,966		85,410	5,869	13
14	34	BUILDING RENT	AVAIL. CENSUS DAYS 901,760	11	5,526		85,410	523	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS 901,760	11	35,109		85,410	3,325	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED 10	11	50,000	50,000	1	4,736	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED 50	11	92,000	92,000	5	8,714	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED 40	2	70,000	70,000			18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED 10	11	28,814		1	2,729	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED 50	11	7,164		5	679	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED 40	2	3,060				21
22									22
23									23
24									24
25	TOTALS				\$ 3,148,292	\$ 2,007,253		\$ 291,270	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Workmans Compensation	Direct Allocation					61,327	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				\$	\$		\$ 61,327	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	HUD Loan						\$	\$ 12,784,963			\$ 658,055	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
Working Capital												
6	Shareholders		X					1,000,000		Annual	79,541	6
7	Allocated from Nucare		X								7,308	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						\$	\$ 13,784,963			\$ 744,904	9
B. Non-Facility Related*												
10	Interest Income		X								(96)	10
11	Int Inc. - Jackson Associates		X								(2,479)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(2,575)	14
15	TOTALS (line 9+line14)						\$	\$ 13,784,963			\$ 742,329	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 64,261 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jackson Square Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039834

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-16-209--002-0000</u>	<u>Long Term Care Property</u>	\$ <u>305,121.31</u>	\$ <u>282,452.31</u>
2. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>94,936.32</u>	\$ <u>8,784.16</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>400,057.63</u>	\$ <u>291,236.47</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jackson Square Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039834

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834 Report Period Beginning:

01/01/06 Ending:

12/31/06

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	<u>Facility</u>	<u>89,364</u>	<u>1987</u>	<u>\$ 71,619</u>	1
2	<u>Allocated - 7257 N. Lincoln LLC</u>			<u>14,804</u>	2
3	TOTALS	89,364		\$ 86,423	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	198,972		20	9,949	9,949	59,692	9
10	Various			1988	17,097		20	854	854	5,128	10
11	Various			1989	19,023		20	952	952	5,708	11
12	Various			1990	33,869		20	1,693	1,693	10,160	12
13	Various			1991	10,518		20	526	526	3,156	13
14	Various			1993	3,315		20	166	166	995	14
15	Various			1994	110,244		20	5,512	5,512	35,084	15
16	Various			1995	57,890		20	2,896	2,896	33,372	16
17	Various			1996	131,988		20	6,601	6,601	69,319	17
18	Various			1997	126,299		20	6,411	6,411	59,935	18
19	Various			1998	35,115		20	1,756	1,756	14,976	19
20	Various			1999	67,125		20	3,359	3,359	25,182	20
21	Various			2000	182,497		20	9,126	9,126	62,972	21
22	Various			2001	24,742		20	1,237	1,237	6,869	22
23	Various			2002	118,181		20	11,821	11,821	53,686	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		3,173,042	202,928		95,250	(107,678)	1,715,187	67
68		174,812	8,277		6,006	(2,271)	16,639	68
69			215,855			(215,855)		69
70		\$ 4,484,729	\$ 427,060		\$ 164,115	\$ (262,945)	\$ 2,178,060	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,484,729	\$ 427,060		\$ 164,115	\$ (262,945)	\$ 2,178,060	1
2	Outdoor Signs	2003	6,000		20	600	600	2,400	2
3	Outdoor Signs	2003	11,627		20	1,163	1,163	4,651	3
4	Cctv	2003	1,684		20	168	168	632	4
5	Dr Alarm	2003	886		20	127	127	475	5
6	Tel Lines	2003	1,064		20	106	106	399	6
7	Elevator Repair	2003	6,276		20	314	314	1,151	7
8	Wall Paper	2003	1,008		20			1,008	8
9	Tel Lines	2003	999		20	100	100	358	9
10	Tel Lines	2003	873		20	87	87	313	10
11	Fire Alarm	2003	858		20	123	123	439	11
12	Tel Lines	2003	1,075		20	108	108	385	12
13	Install Tel	2003	629		20	63	63	225	13
14	Install Telephone	2003	977		20	98	98	350	14
15	Drapery	2003	1,586		20	159	159	582	15
16	Conc Drive	2003	14,371		20	1,437	1,437	5,150	16
17	Land Improvement	2003	740		20	49	49	173	17
18	Limestone Planters	2003	5,960		20	397	397	1,424	18
19	Landscape	2003	2,291		20	153	153	535	19
20	Carpet	2003	2,414		20	345	345	1,150	20
21	New Sign	2003	999		20	100	100	316	21
22	Window Treatment	2003	399		20	40	40	130	22
23	Lights	2003	1,522		20	152	152	482	23
24	Vinal Tile	2003	739		20	49	49	152	24
25	Fire Alarm	2003	1,196		20	171	171	541	25
26	Nurse Station	2003	9,500		20	950	950	3,404	26
27	Medical Room	2003	2,900		20	290	290	1,039	27
28	Medical Room - F14	2003	2,900		20	290	290	1,039	28
29	Locksets	2003	1,073		20	107	107	393	29
30	Locksets	2003	233		20	23	23	85	30
31	Waste Water Disposal	2003	1,569		20	157	157	575	31
32	Glass Installation	2003	705		20	71	71	253	32
33	Locks	2003	769		20	77	77	263	33
34	TOTAL (lines 1 thru 33)		\$ 4,570,551	\$ 427,060		\$ 172,189	\$ (254,871)	\$ 2,208,532	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,570,551	\$ 427,060		\$ 172,189	\$ (254,871)	\$ 2,208,532	1
2	Toilets	2003	531		20	53	53	164	2
3	Faucets	2003	519		20	52	52	186	3
4	Boiler Repairs	2003	1,088		20	91	91	363	4
5	Motor	2003	710		20	71	71	260	5
6	Pump Motor	2003	824		20	82	82	268	6
7	Elevator	2003	534		20	27	27	85	7
8	Corner Guards	2003	527		20	53	53	176	8
9	Thermal Expansion Tank	2003	583		20	58	58	233	9
10	Hot Water Heater	2003	11,795		20	1,180	1,180	4,718	10
11	Wiring, Electric Work	2003	861		20	86	86	265	11
12	Wiring, Electric Work	2003	971		20	97	97	299	12
13	Wiring, Electric Work	2003	1,572		20	157	157	485	13
14	Wiring, Electric Work	2003	1,440		20	144	144	444	14
15	Wiring, Electric Work	2003	1,105		20	111	111	341	15
16	Submersible Pump	2004	1,249		20	125	125	375	16
17	Wiring For Printers	2004	724		20	72	72	205	17
18	Telephone Lines	2004	1,151		20	115	115	317	18
19	Nurses Station Service	2004	1,141		20	76	76	203	19
20	Front Door Locking System	2004	542		20	77	77	206	20
21	Telephone System Service	2004	1,036		20	104	104	250	21
22	Table Top	2004	1,200		20	120	120	290	22
23	Alarm Service On Doors	2004	1,502		20	215	215	501	23
24	Video Recorder Monitor System	2004	1,766		20	252	252	589	24
25	Data Cables	2004	1,223		20	122	122	275	25
26	Control Panel	2004	865		20	58	58	130	26
27	Extending Vents	2004	1,255		20	126	126	282	27
28	Ceiling Fixtures, Monitoring System	2004	873		20	87	87	189	28
29	Front Door Locking System	2004	869		20	124	124	269	29
30	Paging System	2004	3,293		20	470	470	980	30
31	Activity Room Signs	2004	886		20	89	89	199	31
32	Replace Glass In Resident Rooms	2004	575		20	58	58	173	32
33	Polished Wire Glass/Safety Galss	2004	725		20	73	73	218	33
34	TOTAL (lines 1 thru 33)		\$ 4,614,486	\$ 427,060		\$ 176,814	\$ (250,246)	\$ 2,222,470	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,614,486	\$ 427,060		\$ 176,814	\$ (250,246)	\$ 2,222,470	1
2	Replace Glass In Resident Rooms	2004	620		20	62	62	186	2
3	Light Fixtures	2005	1,190		20	119	119	238	3
4	Light Fixtures	2005	1,190		20	119	119	238	4
5	Light Fixtures	2005	1,233		20	123	123	247	5
6	Light Fixtures	2005	808		20	81	81	148	6
7	Light Fixtures	2005	1,133		20	113	113	198	7
8	Light Fixtures	2005	850		20	85	85	135	8
9	Light Fixtures	2005	1,133		20	113	113	179	9
10	Light Fixtures	2005	1,180		20	118	118	207	10
11	Block Heater On Generator	2005	1,327		20	190	190	300	11
12	Ceiling Tiles	2005	650		20	33	33	54	12
13	Ceiling Tiles	2005	28,859		20	1,443	1,443	2,044	13
14	Wallpaper	2005	850		20	567	567	850	14
15	Sprinkler System	2005	3,375		20	338	338	478	15
16	Landscaping	2005	7,711		20	514	514	685	16
17	Ceiling Tiles	2005	650		20	33	33	46	17
18	Light Fixtures	2005	1,416		20	142	142	189	18
19	Patio Cover	2005	6,840		20	684	684	798	19
20	Plumbing Fixtures	2005	1,117		20	74	74	87	20
21	Horizontal Heat Pump	2005	2,593		20	259	259	303	21
22	Elevator Work	2005	71,890		20	3,595	3,595	4,194	22
23	Wallpaper	2005	844		20	633	633	844	23
24	Floor Tile	2005	731		20	49	49	61	24
25	Window Treatment	2005	1,058		20	106	106	123	25
26	Fire System Repairs	2005	829		20	118	118	158	26
27	Fire Alarm Equipment	2005	13,934		20	1,991	1,991	2,654	27
28	Plumbing Fixtures	2005	350		20	23	23	27	28
29	Light Fixtures	2005	2,214		20	221	221	258	29
30	Ceiling Tiles	2005	665		20	33	33	42	30
31	Counters, Cabinets, Desks	2005	19,060		20	3,812	3,812	4,765	31
32	Elevator Work	2005	10,000		20	500	500	542	32
33	Carpeting	2005	2,823		20	403	403	437	33
34	TOTAL (lines 1 thru 33)		\$ 4,803,609	\$ 427,060		\$ 193,508	\$ (233,552)	\$ 2,244,185	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,803,609	\$ 427,060		\$ 193,508	\$ (233,552)	\$ 2,244,185	1
2	Cubicle Curtains	2005	1,055		20	106	106	114	2
3	Floor Tiles	2005	953		20	64	64	79	3
4	Ceiling Tile	2005	913		20	61	61	71	4
5	Floor Tile	2005	1,484		20	99	99	115	5
6	Tile Flooring	2005	427		20	28	28	33	6
7	Floor Tiling	2005	199		20	13	13	14	7
8	Floor Tiling	2005	1,647		20	110	110	119	8
9	Wallpaper	2005	805		20	537	537	805	9
10	Boiler	2005	5,364		20	447	447	894	10
11	Water Pump	2005	3,246		20	325	325	541	11
12	Cabling And Phone Upgrades	2005	16,403		20	1,640	1,640	1,777	12
13	Plumbing Work	2005	678		20	68	68	130	13
14	Generator Work	2005	1,248		20	125	125	229	14
15	Data Cables	2005	1,040		20	104	104	165	15
16	Fire System Work	2005	1,670		20	239	239	378	16
17	Data Lines	2005	825		20	83	83	103	17
18	Ceiling Tiles	2005	665		20	33	33	36	18
19	Paging System	2005	958		20	96	96	96	19
20	Cctv - Staff Dining Room	2005	1,237		20	62	62	124	20
21	Telephone Lines	2005	1,101		20	55	55	110	21
22	Acoustical Tiles	2005	665		20	33	33	67	22
23	Doors For Elevators	2006	5,260		20	263	263	263	23
24	Pergola	2006	1,250		20	125	125	125	24
25	Tiles Excelon Imp Textur	2006	1,312		20	87	87	87	25
26	Tiles Excelon Imp Textur	2006	1,698		20	113	113	113	26
27	Light Fixtures	2006	1,395		20	140	140	140	27
28	Interior Design Services	2006	1,185		20	109	109	109	28
29	Wall Covering	2006	3,690		20	677	677	677	29
30	Paint Hallway Walls	2006	1,250		20	115	115	115	30
31	Elevator Lighting	2006	850		20	85	85	85	31
32	Tiles Exelon Imp Textur	2006	1,012		20	62	62	62	32
33	Tiles Exelon Imp Textur	2006	1,892		20	95	95	95	33
34	TOTAL (lines 1 thru 33)		\$ 4,866,986	\$ 427,060		\$ 199,707	\$ (227,353)	\$ 2,252,055	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,866,986	\$ 427,060		\$ 199,707	\$ (227,353)	\$ 2,252,055	1
2	Smoke Dampers	2006	1,280		20	125	125	125	2
3	Smoke Dampers (Credit Applied)	2006	(109)		20	(5)	(5)	(5)	3
4	CI Series Pump	2006	3,729		20	280	280	280	4
5	Water Booster Compact	2006	1,914		20	144	144	144	5
6	Wall Covering	2006	1,060		20	159	159	159	6
7	Window Treatment	2006	4,775		20	398	398	398	7
8	Windows	2006	5,436		20	362	362	362	8
9	Windows	2006	5,436		20	362	362	362	9
10	Wall Covering	2006	1,864		20	249	249	249	10
11	Smoke Detectors	2006	1,170		20	111	111	111	11
12	Bronze Anodized Finish Medium Stile Aluminum Door	2006	10,450		20	697	697	697	12
13	Insulated Windows	2006	13,796		20	920	920	920	13
14	Insulated Windows	2006	13,796		20	920	920	920	14
15	Excelon Imp Textur	2006	410		20	16	16	16	15
16	Water Heater	2006	11,525		20	640	640	640	16
17	Latex Paint	2006	311		20	207	207	207	17
18	Chair Rail	2006	360		20	12	12	12	18
19	Chair Rail	2006	3,307		20	96	96	96	19
20	New Roof	2006	67,500		20	3,938	3,938	3,938	20
21	Marathon Ac Motor	2006	1,056		20	70	70	70	21
22	Wallcovering	2006	2,638		20	352	352	352	22
23	Wallcovering	2006	5,265		20	614	614	614	23
24	Handrails	2006	3,689		20	108	108	108	24
25	Handrails	2006	3,693		20	108	108	108	25
26	Watermark Moire Buttermilk	2006	6,206		20	362	362	362	26
27	Johnsonite Cove Base	2006	4,632		20	309	309	309	27
28	Johnsonite Covebase	2006	751		20	44	44	44	28
29	Excelon Imp Textur Tile	2006	652		20	25	25	25	29
30	Repair And Paint Walls, Install Chair Rails And Basecove	2006	20,900		20	1,219	1,219	1,219	30
31	Repair And Wallpaper Walls, Install Chair Rails And Basecove	2006	24,000		20	1,400	1,400	1,400	31
32	Cubicle Curtains	2006	28,536		20	1,597	1,597	1,597	32
33	Cubicle Curtains (Credit Applied)	2006	(1,162)		20	(58)	(58)	(58)	33
34	TOTAL (lines 1 thru 33)		\$ 5,115,852	\$ 427,060		\$ 215,488	\$ (211,572)	\$ 2,267,836	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 5,115,852	\$ 427,060		\$ 215,488	\$ (211,572)	\$ 2,267,836	1
2	Electric Magnet Door Holders	2006	1,064		20	71	71	71	2
3	Electric Magnet Door Holders	2006	1,021		20	68	68	68	3
4	Electric Magnet Door Holders	2006	1,610		20	107	107	107	4
5	100 5-Gal Hd Clear	2006	522		20	305	305	305	5
6	Ceiling Tiles	2006	706		20	21	21	21	6
7	Plumbing To Replace Fittings And Pipe	2006	2,000		20	117	117	117	7
8	Plumbing To Replace Fittings And Pipe	2006	4,450		20	223	223	223	8
9	Handrails	2006	3,458		20	86	86	86	9
10	Insulated Glass	2006	537		20	36	36	36	10
11	Cement Curb	2006	2,800		20	62	62	62	11
12	Signage With Braille	2006	1,701		20	71	71	71	12
13	Recaulk All Openings At 3Rd Floor Therapy Rooms	2006	2,507		20	84	84	84	13
14	Handrails	2006	3,308		20	138	138	138	14
15	Improvement	2006	286		20	17	17	17	15
16	Electric Magnet Door Holders	2006	988		20	66	66	66	16
17	1700 Feet Oak Chair Rail	2006	2,662		20	67	67	67	17
18	2 Elevator Controls Duplex Hydro Soft Start	2006	5,378		20	403	403	403	18
19	Heating And Cooling Equipment Including Ducts	2006	1,749		20	73	73	73	19
20	10 Touchbar Von Dupin Exit Devices	2006	5,100		20	340	340	340	20
21	Foundation Work	2006	4,500		20	75	75	75	21
22	Plywood For Dialysis Unit	2006	1,333		20	22	22	22	22
23	Tile For Dialysis Unit	2006	1,175		20	20	20	20	23
24	Electrical Work For Dialysis Unit	2006	9,950		20	166	166	166	24
25	Plumbing Work For Dialysis Unit	2006	23,000		20	383	383	383	25
26	Paint	2006	2,976		20	12	12	12	26
27	Oak Chair Rail	2006	871		20	4	4	4	27
28	Security System	2006	1,137		20	57	57	57	28
29	Wiring	2006	1,226		20	61	61	61	29
30	Security System	2006	1,847		20	85	85	85	30
31	Exit Doors Alarm System	2006	957		20	40	40	40	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	1	
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	34	

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Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	1	
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	1	
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12J, Carried Forward	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	1	
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12K, Carried Forward	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	1	
2									2
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	34	

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Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12L, Carried Forward	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116		1
2									2
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116		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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12M, Carried Forward	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	1	
2									2
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12N, Carried Forward	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	1	
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116	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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12O, Carried Forward	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116		1
2									2
3									3
4									4
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116		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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12P, Carried Forward	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116		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)	\$ 5,206,671	\$ 427,060		\$ 218,768	\$ (208,292)	\$ 2,271,116		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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	234		1987	1980	\$ 3,173,042	\$ 202,928	39	\$ 95,250	\$ (107,678)	\$ 1,715,187	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		3,173,042	202,928		95,250	(107,678)	1,715,187	

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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated - 7257 N. Lincoln Ave LLC		2004	2004	\$ 133,239	\$ 3,416	35	\$ 3,807	\$ 391	\$ 11,896	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Allocated - Nucare Services Corp.			2003	1,109	77	20	56	(21)	173	9
10	Allocated - Nucare Services Corp.			2004	22,524	1,558	20	1,127	(431)	3,054	10
11	Allocated - Nucare Services Corp.			2005	1,335	92	20	67	(25)	124	11
12	Allocated - Nucare Services Corp.			2006	1,811	125	20	33	(92)	33	12
13											13
14	Allocated - 7257 N. Lincoln Ave LLC			2004	12,146	2,501	20	784	(1,717)	1,028	14
15	Allocated - 7257 N. Lincoln Ave LLC			2005	2,648	508	20	132	(376)	331	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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 Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	174,812	\$	8,277	\$	6,006	\$	(2,271)	\$	16,639	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 Nsg & Rehab Ctr # 0039834 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,008,832	\$ 5,184	\$ 124,767	\$ 119,583	10	\$ 642,748	71
72	Current Year Purchases	112,726	406	13,095	12,689	10	13,095	72
73	Fully Depreciated Assets	42,103				10	42,103	73
74								74
75	TOTALS	\$ 1,163,661	\$ 5,590	\$ 137,862	\$ 132,272		\$ 697,946	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1992 FORD VAN	1990	\$ 2,282	\$	\$	\$	5	\$	76
77										77
78										78
79										79
80	TOTALS			\$ 2,282	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,459,037	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 432,650	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 356,630	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (76,020)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,969,062	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	\$	\$	86
87	WATER FAUCETS - 2001	1,361			87
88	RESURFACE PK LOT/SIDEWALK - 200	2,778			88
89					89
90					90
91	TOTALS	\$ 20,903	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from Nucare Services Corp				523			5
6								6
7	TOTAL				\$ 523			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 9,408 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	Allocated from Nucare Services Corp		\$	\$ 2,502	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,502	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 235,803	\$		\$ 235,803	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			65,506			65,506	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			215,761			215,761	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescripts			235,942	(205)		235,737	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					(30)		(30)	12
13	Other (specify): See Supplemental					1,882	48,877		50,759	13
14	TOTAL			\$		\$ 754,894	\$ 48,642		\$ 803,536	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr# 0039834Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,386	\$ 373,343	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,222,723	2,287,765	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,907	139,140	6
7	Other Prepaid Expenses	17,586	17,586	7
8	Accounts Receivable (owners or related parties)	(570,307)	(570,307)	8
9	Other(specify): <u>See Attached Schedule</u>	13,494	732,027	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,763,789	\$ 2,979,554	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		888,457	13
14	Buildings, at Historical Cost		3,333,738	14
15	Leasehold Improvements, at Historical Cost	1,527,185	5,951,605	15
16	Equipment, at Historical Cost	1,006,139	1,504,779	16
17	Accumulated Depreciation (book methods)	(1,356,201)	(4,531,625)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		195,368	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	54,080	54,080	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,231,203	\$ 7,396,402	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,994,992	\$ 10,375,956	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 145,123	\$ 145,273	26
27	Officer's Accounts Payable		198,244	27
28	Accounts Payable-Patient Deposits	(785)	(785)	28
29	Short-Term Notes Payable	1,000,000	1,000,000	29
30	Accrued Salaries Payable	376,332	376,332	30
31	Accrued Taxes Payable (excluding real estate taxes)	50,707	50,707	31
32	Accrued Real Estate Taxes(Sch.IX-B)		314,275	32
33	Accrued Interest Payable		54,549	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	36,819	36,819	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	21,716	129,905	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,629,912	\$ 2,305,319	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,784,963	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 12,784,963	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,629,912	\$ 15,090,282	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,365,080	\$ (4,714,326)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,994,992	\$ 10,375,956	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,741,217	1
2	Restatements (describe):		2
3	Allowance For Doubtful Accounts	(245,000)	3
4	Management Fees	227,125	4
5	Rounding	3	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,723,345	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(358,265)	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)	\$ (358,265)	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)	\$ 1,365,080	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	\$ 9,300,576	1
2	Discounts and Allowances for all Levels	(279,222)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,021,354	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,223,419	6
7	Oxygen	7,704	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,231,123	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	129,000	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	63,529	19
20	Radiology and X-Ray	14,017	20
21	Other Medical Services	459,777	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 666,323	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	96	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 96	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	7,738	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,738	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,926,634	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,785,899	31
32	Health Care	3,821,475	32
33	General Administration	2,505,203	33
B. Capital Expense			
34	Ownership	2,130,500	34
C. Ancillary Expense			
35	Special Cost Centers	913,707	35
36	Provider Participation Fee	128,115	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,284,899	40
41	Income before Income Taxes (line 30 minus line 40)**	(358,265)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (358,265)	43

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

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

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

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

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

0039834

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	2,325	\$ 100,133	\$ 43.07	1
2	Assistant Director of Nursing	1,244	1,294	58,052	44.86	2
3	Registered Nurses	22,910	24,977	597,902	23.94	3
4	Licensed Practical Nurses	44,170	47,120	1,063,769	22.58	4
5	CNAs & Orderlies	112,433	123,055	1,224,893	9.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,869	2,086	30,130	14.44	9
10	Activity Assistants	5,128	5,864	61,250	10.45	10
11	Social Service Workers	7,419	6,258	130,289	20.82	11
12	Dietician	3,419	3,829	66,455	17.36	12
13	Food Service Supervisor					13
14	Head Cook	4,901	5,421	52,228	9.63	14
15	Cook Helpers/Assistants	19,908	22,028	191,261	8.68	15
16	Dishwashers					16
17	Maintenance Workers	4,734	5,157	82,989	16.09	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	626	703	24,317	34.59	20
21	Assistant Administrator	1,947	2,086	21,275	10.20	21
22	Other Administrative	846	846	73,322	86.67	22
23	Office Manager					23
24	Clerical	12,374	13,247	210,766	15.91	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	8,460	9,270	119,676	12.91	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,587	4,876	110,171	22.59	33
34	TOTAL (lines 1 - 33)	258,906	280,442	\$ 4,218,878 *	\$ 15.04	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 12,749	01-03	35
36	Medical Director	Monthly	41,500	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	6,598	10-03	38
39	Pharmacist Consultant	Monthly	3,374	10-03	39
40	Physical Therapy Consultant	Monthly	3,157	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	39	943	11-03	44
45	Social Service Consultant	39	2,098	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	78	\$ 74,643		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	3,515	118,168	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,515	\$ 118,168		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nsg & Rehab Ctr

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 \$12,671
- (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? _____
- (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. \$ 32,323 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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 128,115
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 17,104 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. \$ _____
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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