

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0039834

Facility Name: Jackson Square Nursing & 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: 7/1/1994

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 01/01/07 to 12/31/07 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) _____
Paid Preparer	(Type or Print Name) <u>Richard S. Sgarlata, C.P.A.</u>
	(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>
Paid Preparer	(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 Nursing & Rehab Ctr

0039834 Report Period Beginning: 01/01/07 Ending: 12/31/07

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>65,509</u>	<u>1,174</u>	<u>11,092</u>	<u>77,775</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>65,509</u>	<u>1,174</u>	<u>11,092</u>	<u>77,775</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.06%

D. How many bed-hold days during this year were paid by the Department? 2,247 (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 234 and days of care provided 10,065

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: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr # 0039834 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	328,611	91,646	12,254	432,511		432,511		432,511		1
2	Food Purchase		380,962		380,962	(18,670)	362,292	(135)	362,157		2
3	Housekeeping		51,948	381,362	433,310		433,310		433,310		3
4	Laundry		17,029		17,029		17,029		17,029		4
5	Heat and Other Utilities			448,196	448,196		448,196	(35,851)	412,345		5
6	Maintenance	81,446	67,033	171,715	320,194		320,194	1,555	321,749		6
7	Other (specify):*										7
8	TOTAL General Services	410,057	608,618	1,013,527	2,032,202	(18,670)	2,013,532	(34,432)	1,979,101		8
	B. Health Care and Programs										
9	Medical Director			43,200	43,200		43,200		43,200		9
10	Nursing and Medical Records	3,623,462	262,586	35,376	3,921,424		3,921,424	(17,786)	3,903,638		10
10a	Therapy			5,307	5,307		5,307		5,307		10a
11	Activities	86,568	10,730	1,444	98,742		98,742		98,742		11
12	Social Services	134,971		2,916	137,887		137,887		137,887		12
13	CNA Training										13
14	Program Transportation			6,918	6,918		6,918		6,918		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,845,001	273,316	95,161	4,213,478		4,213,478	(17,786)	4,195,692		16
	C. General Administration										
17	Administrative	159,873		931,250	1,091,123		1,091,123	(875,350)	215,773		17
18	Directors Fees										18
19	Professional Services			99,634	99,634	(557)	99,077	(3,132)	95,945		19
20	Dues, Fees, Subscriptions & Promotions			95,313	95,313		95,313	(46,407)	48,906		20
21	Clerical & General Office Expenses	249,520	43,325	210,616	503,461		503,461	27,342	530,803		21
22	Employee Benefits & Payroll Taxes			782,621	782,621	18,670	801,291		801,291		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,143	9,143		9,143	(594)	8,549		24
25	Other Admin. Staff Transportation			1,697	1,697		1,697	1,222	2,919		25
26	Insurance-Prop.Liab.Malpractice			265,799	265,799		265,799	17,702	283,501		26
27	Other (specify):*							33,196	33,196		27
28	TOTAL General Administration	409,393	43,325	2,396,073	2,848,791	18,113	2,866,904	(846,021)	2,020,882		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,664,451	925,259	3,504,761	9,094,471	(557)	9,093,914	(898,239)	8,195,675		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 Nursing & Rehab Ctr #0039834 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			200,428	200,428		200,428	171,139	371,567		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			71,256	71,256		71,256	643,607	714,863		32
33	Real Estate Taxes					557	557	226,795	227,352		33
34	Rent-Facility & Grounds			1,999,949	1,999,949		1,999,949	(1,999,438)	511		34
35	Rent-Equipment & Vehicles			7,139	7,139		7,139	3,869	11,008		35
36	Other (specify):*							69,473	69,473		36
37	TOTAL Ownership			2,278,772	2,278,772	557	2,279,329	(884,555)	1,394,774		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	4,308	191,811	974,459	1,170,578		1,170,578		1,170,578		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):*	94,808			94,808		94,808	(94,808)			43
44	TOTAL Special Cost Centers	99,116	191,811	1,102,574	1,393,501		1,393,501	(94,808)	1,298,693		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,763,567	1,117,070	6,886,107	12,766,744		12,766,744	(1,877,602)	10,889,142		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr

0039834

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,121)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(66,743)	30		9
10	Interest and Other Investment Income	(12,054)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(57)	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	(13,354)	20		18
19	Entertainment	(2,524)	24		19
20	Contributions	(13,110)	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	(131,292)	21		24
25	Fund Raising, Advertising and Promotional	(17,697)	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	(205,449)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (467,401)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	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)	(1,410,201)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,410,201)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,877,602)		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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1 Patient Needs	\$ (10,552)	10
2 Patient Clothing	(7,182)	10
3 Bank Charges	(14,783)	23
4 Fuel	(525)	20
5 CPE Fees	(2,991)	20
6 Capitalized R & M	(2,721)	06
7		7
8 Non-Allowable Legal Fees	(15,300)	19
9 Food service Income	(78)	02
10 Clinic Allocation - RE Taxes	(20,345)	33
11 Clinic Allocation - Utilities	(33,231)	05
12 Non-Allowable Salaries	(94,808)	43
13 Duty Duty Income	(52)	10
14 Board of Elect. Income	(325)	21
15 Seminar Refund	(10)	24
16 Vendor Refund	(350)	21
17 Copies	(862)	21
18 Non-Care Depreciation	(1,254)	30
19		19
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100		100
101 Total	(265,449)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	(135)											(135)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(38,352)		2,501									(35,851)	5
6	Maintenance	(2,721)		4,276									1,555	6
7	Other (specify):*													7
8	TOTAL General Services	(41,208)		6,777									(34,432)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17,786)											(17,786)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(17,786)											(17,786)	16
	C. General Administration													
17	Administrative			(875,350)									(875,350)	17
18	Directors Fees													18
19	Professional Services	(15,380)		12,247									(3,132)	19
20	Fees, Subscriptions & Promotions	(47,677)		1,270									(46,407)	20
21	Clerical & General Office Expenses	(147,612)		174,954									27,342	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,534)		1,940									(594)	24
25	Other Admin. Staff Transportation			1,222									1,222	25
26	Insurance-Prop.Liab.Malpractice		16,236	1,466									17,702	26
27	Other (specify):*			33,196									33,196	27
28	TOTAL General Administration	(213,203)	16,236	(649,055)									(846,021)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(272,197)	16,236	(642,278)									(898,239)	29

STATE OF ILLINOIS

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	(67,997)	227,071	12,065									171,139	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12,054)	647,384	8,277									643,607	32
33	Real Estate Taxes	(20,345)	241,803	5,337									226,795	33
34	Rent-Facility & Grounds		(1,999,949)	511									(1,999,438)	34
35	Rent-Equipment & Vehicles			3,869									3,869	35
36	Other (specify):*		69,473										69,473	36
37	TOTAL Ownership	(100,396)	(814,218)	30,059									(884,555)	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):*	(94,808)											(94,808)	43
44	TOTAL Special Cost Centers	(94,808)											(94,808)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(467,401)	(797,982)	(612,219)									(1,877,602)	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	\$ 1,999,949	Jackson Square Association		\$	\$ (1,999,949)	1
2	V	32 Interest	2,969	Jackson Square Association			(2,969)	2
3	V	30 Depreciation		Jackson Square Association		227,071	227,071	3
4	V	36 Amortization		Jackson Square Association		5,965	5,965	4
5	V	33 Real Estate Taxes		Jackson Square Association		241,803	241,803	5
6	V	26 Property & Liability Insurance		Jackson Square Association		16,236	16,236	6
7	V	32 Interest -HUD Loan		Jackson Square Association		650,353	650,353	7
8	V	36 MIP Expense		Jackson Square Association		63,508	63,508	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,002,918			\$ 1,204,936	\$ * (797,982)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr # 0039834 Report Period Beginning: 01/01/07 Ending: 12/31/07

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%	\$ 2,501	\$ 2,501	15
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.		4,276	4,276	16
17	V	17 ADMIN. - NON-OWNER		NUCARE SERVICES CORP.		30,818	30,818	17
18	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.		12,247	12,247	18
19	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.		1,270	1,270	19
20	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.		174,954	174,954	20
21	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.		1,940	1,940	21
22	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.		1,222	1,222	22
23	V	26 INSURANCE		NUCARE SERVICES CORP.		1,466	1,466	23
24	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.		23,514	23,514	24
25	V	30 DEPRECIATION		NUCARE SERVICES CORP.		12,065	12,065	25
26	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.		8,277	8,277	26
27	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.		5,337	5,337	27
28	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.		511	511	28
29	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.		3,869	3,869	29
30	V	17 ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.		16,010	16,010	30
31	V	17 ADMIN. - B. CARR		NUCARE SERVICES CORP.		9,072	9,072	31
32	V	17 ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.				32
33	V	27 EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.		7,789	7,789	33
34	V	27 EMP. BEN. - B. CARR		NUCARE SERVICES CORP.		1,893	1,893	34
35	V	27 EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.				35
36	V							36
37	V	17 MANAGEMENT FEES	931,250	NUCARE SERVICES CORP.			(931,250)	37
38	V							38
39	Total		\$ 931,250			\$ 319,031	\$ * (612,219)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Workman Compensation	\$ 81,267	Diamond Insurance	40.00%	\$ 81,267	\$	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		\$ 81,267			\$ 81,267	\$ *	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.

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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr # 0039834 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	0.89	1.78%	Allocated	\$ 16,010	17-7	1
2	Barry Carr	Owner	Administrative	4.75%	See Attached	4.45	8.90%	Allocated	9,072	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	\$ 25,082		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 Nursing & Rehab Ctr

0039834

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Nursing & Rehab Ctr

0039834

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 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

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	5	UTILITIES	AVAIL. CENSUS DAYS 960,286	12	\$ 28,115	\$	85,410	\$ 2,501	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 960,286	12	48,079		85,410	4,276	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS 960,286	12	346,499	346,499	85,410	30,818	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 960,286	12	137,702		85,410	12,247	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 960,286	12	14,277		85,410	1,270	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 960,286	12	1,967,057	1,688,717	85,410	174,954	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 960,286	12	21,810		85,410	1,940	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 960,286	12	13,739		85,410	1,222	8
9	26	INSURANCE	AVAIL. CENSUS DAYS 960,286	12	16,477		85,410	1,466	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS 960,286	12	264,372		85,410	23,514	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS 960,286	12	135,649		85,410	12,065	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 960,286	12	93,063		85,410	8,277	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 960,286	12	60,000		85,410	5,337	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS 960,286	12	5,749		85,410	511	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS 960,286	12	43,501		85,410	3,869	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED 10	12	180,000	180,000	85,410	16,010	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED 50	12	102,000	102,000	85,410	9,072	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED 40	2	80,000	80,000	85,410		18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED 10	12	87,577		85,410	7,789	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED 50	12	21,286		85,410	1,893	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED 40	2	16,421		85,410		21
22									22
23									23
24									24
25	TOTALS				\$ 3,683,372	\$ 2,397,215		\$ 319,031	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr

0039834

Report Period Beginning: 01/01/07

Ending: 12/31/07

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		\$	\$		\$ 81,267	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				\$	\$		\$ 81,267	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 Nursing & Rehab Ctr

0039834

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 Nursing & Rehab Ctr

0039834

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr

0039834

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Nursing & Rehab Ctr

0039834

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Nursing & Rehab Ctr

0039834

Report Period Beginning: 01/01/07

Ending: 12/31/07

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		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	HUD Loan		X				\$	\$ 12,630,975			\$ 650,353	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
	Working Capital																
6	Shareholders		X					2,100,000		Annual	71,256	6					
7	Alloc. From Nucare		X								8,277	7					
8	See Supplemental Schedule											8					
9	TOTAL Facility Related						\$	\$ 14,730,975			\$ 729,886	9					
	B. Non-Facility Related*																
10	Interest Income		X								(12,054)	10					
11	Int. Income - Jackson Assoc.		X								(2,969)	11					
12												12					
13	See Supplemental Schedule											13					
14	TOTAL Non-Facility Related						\$	\$			\$ (15,023)	14					
15	TOTALS (line 9+line14)						\$	\$ 14,730,975			\$ 714,863	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 63,508 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 Nursing & Rehab Ctr # 0039834 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

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

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

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

** 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 Nursing & Rehab Ctr# 0039834 Report Period Beginning: 01/01/07Ending: 12/31/07

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2006 report.			\$	314,275	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	256,251	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(58,024)	3
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	284,820	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	557	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 1,673 For 1989+ 1992 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	227,353	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:						
	2002	334,808	8	FOR BHF USE ONLY		
	2003	295,482	9			
	2004	278,008	10			
	2005	282,452	11			
	2006	250,914	12			
2007 Accruals = \$271,914 x 1.05 = \$284,820						
Tax refund was not offset against expense since the revenue did not relate to rate setting years.						
Alloc. From Nuicare Services Corp. - \$5,337						
13	FROM R. E. TAX STATEMENT FOR 2006	\$				13
14	PLUS APPEAL COST FROM LINE 5	\$				14
15	LESS REFUND FROM LINE 6	\$				15
16	AMOUNT TO USE FOR RATE CALCULATION	\$				16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jackson Square Nursing & 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-16-209-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>271,257.58</u>	\$ <u>250,913.58</u>
2. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>100,273.68</u>	\$ <u>8,918.57</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>371,531.26</u>	\$ <u>259,832.15</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Nursing & 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 Nursing & Rehab Ctr

0039834 Report Period Beginning:

01/01/07 Ending:

12/31/07

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>	<u>1</u>
2	<u>Alloc. From 7257 N. Lincoln</u>			<u>14,231</u>	<u>2</u>
3	TOTALS	89,364		\$ 85,850	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	9,119	9,119	68,812	9
10	Various		1988		17,097		20	854	854	5,983	10
11	Various		1989		19,023		20	952	952	6,659	11
12	Various		1990		33,869		20	1,693	1,693	11,854	12
13	Various		1991		10,518		20	526	526	3,681	13
14	Various		1993		3,315		20	166	166	1,161	14
15	Various		1994		110,244		20	5,512	5,512	40,596	15
16	Various		1995		57,890		20	2,896	2,896	36,268	16
17	Various		1996		131,988		20	6,601	6,601	75,919	17
18	Various		1997		126,299		20	6,373	6,373	66,305	18
19	Various		1998		35,115		20	1,756	1,756	16,732	19
20	Various		1999		67,125		20	3,359	3,359	28,533	20
21	Various		2000		182,497		20	9,126	9,126	72,093	21
22	Various		2001		24,742		20	1,237	1,237	8,104	22
23	Various		2002		118,181		20	11,821	11,821	65,503	23
24	Various		2003		108,882		20	10,336	10,336	49,089	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		3,245,749	227,071		101,375	(125,696)	1,826,996	67
68		167,445	5,993		5,799	(194)	21,719	68
69			199,174			(199,174)		69
70		\$ 4,658,951	\$ 432,238		\$ 179,501	\$ (252,737)	\$ 2,406,007	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 4,658,951	\$ 432,238		\$ 179,501	\$ (252,737)	\$ 2,406,007	1
2	Submersible Pump	2004	1,249		20	125	125	500	2
3	Wiring For Printers	2004	724		20	72	72	278	3
4	Telephone Lines	2004	1,151		20	115	115	432	4
5	Nurses Station Service	2004	1,141		20	76	76	279	5
6	Front Door Locking System	2004	542		20	77	77	284	6
7	Telephone System Service	2004	1,036		20	104	104	354	7
8	Table Top	2004	1,200		20	120	120	410	8
9	Activity Room Signs	2004	886		20	89	89	288	9
10	Replace Glass In Resident Rooms	2004	575		20	58	58	230	10
11	Polished Wire Glass/Safety Galss	2004	725		20	73	73	290	11
12	Replace Glass In Resident Rooms	2004	620		20	62	62	248	12
13	Wallpaper	2005	850		20			850	13
14	Sprinkler System	2005	3,375		20	338	338	816	14
15	Landscaping	2005	7,711		20	514	514	1,200	15
16	Ceiling Tiles	2005	650		20	33	33	79	16
17	Light Fixtures	2005	1,416		20	142	142	330	17
18	Patio Cover	2005	6,840		20	684	684	1,482	18
19	Plumbing Fixtures	2005	1,117		20	74	74	161	19
20	Horizontal Heat Pump	2005	2,593		20	259	259	562	20
21	Elevator Work	2005	71,890		20	3,595	3,595	7,788	21
22	Wallpaper	2005	844		20			844	22
23	Floor Tile	2005	731		20	49	49	110	23
24	Window Treatment	2005	1,058		20	106	106	229	24
25	Fire System Repairs	2005	829		20	118	118	276	25
26	Fire Alarm Equipment	2005	13,934		20	1,991	1,991	4,645	26
27	Plumbing Fixtures	2005	350		20	23	23	51	27
28	Light Fixtures	2005	2,214		20	221	221	480	28
29	Ceiling Tiles	2005	665		20	33	33	75	29
30	Counters, Cabinets, Desks	2005	19,060		20	3,812	3,812	8,577	30
31	Elevator Work	2005	10,000		20	500	500	1,042	31
32	Carpeting	2005	2,823		20	403	403	840	32
33	Cubicle Curtains	2005	1,055		20	106	106	220	33
34	TOTAL (lines 1 thru 33)		\$ 4,818,805	\$ 432,238		\$ 193,473	\$ (238,765)	\$ 2,440,257	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 4,818,805	\$ 432,238		\$ 193,473	\$ (238,765)	\$ 2,440,257	1
2	Floor Tiles	2005	953		20	64	64	143	2
3	Ceiling Tile	2005	913		20	61	61	132	3
4	Floor Tile	2005	1,484		20	99	99	214	4
5	Tile Flooring	2005	427		20	28	28	62	5
6	Floor Tiling	2005	199		20	13	13	28	6
7	Floor Tiling	2005	1,647		20	110	110	229	7
8	Wallpaper	2005	805		20			805	8
9	Cabling And Phone Upgrades	2005	8,141		20	814	814	1,696	9
10	Data Lines	2005	825		20	83	83	186	10
11	Ceiling Tiles	2005	665		20	33	33	69	11
12	Paging System	2005	958		20	48	48	100	12
13	Cctv - Staff Dining Room	2005	1,237		20	62	62	129	13
14	Telephone Lines	2005	1,101		20	55	55	115	14
15	Acoustical Tiles	2005	665		20	33	33	69	15
16	Doors For Elevators	2006	5,260		20	263	263	526	16
17	Pergola	2006	1,250		20	125	125	250	17
18	Tiles Excelon Imp Textur	2006	1,312		20	87	87	175	18
19	Tiles Excelon Imp Textur	2006	1,698		20	113	113	226	19
20	Light Fixtures	2006	1,395		20	140	140	279	20
21	Interior Design Services	2006	1,185		20	119	119	227	21
22	Wall Covering	2006	3,690		20	738	738	1,415	22
23	Paint Hallway Walls	2006	1,250		20	125	125	240	23
24	Elevator Lighting	2006	850		20	85	85	170	24
25	Tiles Exelon Imp Textur	2006	1,012		20	67	67	129	25
26	Tiles Exelon Imp Textur	2006	1,892		20	126	126	221	26
27	Smoke Dampers	2006	1,171		20	167	167	293	27
28	CI Series Pump	2006	3,729		20	373	373	653	28
29	Water Booster Compact	2006	1,914		20	191	191	335	29
30	Wall Covering	2006	1,060		20	212	212	371	30
31	Window Treatment	2006	4,775		20	478	478	875	31
32	Windows	2006	5,436		20	544	544	906	32
33	Windows	2006	5,436		20	544	544	906	33
34	TOTAL (lines 1 thru 33)		\$ 4,883,140	\$ 432,238		\$ 199,473	\$ (232,765)	\$ 2,452,431	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 4,883,140	\$ 432,238		\$ 199,473	\$ (232,765)	\$ 2,452,431	1
2	Wall Covering	2006	1,864		20	373	373	621	2
3	Smoke Detectors	2006	1,170		20	167	167	279	3
4	Bronze Anodized Finish Medium Stile Aluminum Door	2006	10,450		20	1,045	1,045	1,742	4
5	Insulated Windows	2006	13,796		20	1,380	1,380	2,299	5
6	Insulated Windows	2006	13,796		20	1,380	1,380	2,299	6
7	Excelon Imp Textur	2006	410		20	27	27	43	7
8	Water Heater	2006	11,525		20	960	960	1,601	8
9	Latex Paint	2006	311		20	104	104	311	9
10	Chair Rail	2006	360		20	18	18	30	10
11	Chair Rail	2006	3,307		20	165	165	262	11
12	New Roof	2006	67,500		20	6,750	6,750	10,688	12
13	Marathon Ac Motor	2006	1,056		20	106	106	176	13
14	Wallcovering	2006	2,638		20	528	528	879	14
15	Wallcovering	2006	5,265		20	1,053	1,053	1,667	15
16	Handrails	2006	3,689		20	184	184	292	16
17	Handrails	2006	3,693		20	185	185	292	17
18	Watermark Moire Buttermilk	2006	6,206		20	621	621	983	18
19	Johnsonite Cove Base	2006	4,632		20	463	463	772	19
20	Johnsonite Covebase	2006	751		20	75	75	119	20
21	Excelon Imp Textur Tile	2006	652		20	43	43	69	21
22	Repair And Paint Walls, Install Chair Rails And Basecove	2006	20,900		20	2,090	2,090	3,309	22
23	Repair And Wallpaper Walls, Install Chair Rails And Basecove	2006	24,000		20	2,400	2,400	3,800	23
24	Cubicle Curtains	2006	27,374		20	2,737	2,737	4,334	24
25	Electric Magnet Door Holders	2006	1,064		20	106	106	177	25
26	Electric Magnet Door Holders	2006	1,021		20	102	102	170	26
27	Electric Magnet Door Holders	2006	1,610		20	161	161	268	27
28	100 5-Gal Hd Clear	2006	522		20	218	218	522	28
29	Ceiling Tiles	2006	706		20	35	35	56	29
30	Plumbing To Replace Fittings And Pipe	2006	2,000		20	200	200	317	30
31	Plumbing To Replace Fittings And Pipe	2006	4,450		20	445	445	668	31
32	Handrails	2006	3,458		20	173	173	259	32
33	Insulated Glass	2006	537		20	54	54	90	33
34	TOTAL (lines 1 thru 33)		\$ 5,123,853	\$ 432,238		\$ 223,821	\$ (208,417)	\$ 2,491,825	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 5,123,853	\$ 432,238		\$ 223,821	\$ (208,417)	\$ 2,491,825	1
2	Cement Curb	2006	2,800		20	187	187	249	2
3	Signage With Braille	2006	1,701		20	170	170	241	3
4	Recaulk All Openings At 3Rd Floor Therapy Rooms	2006	2,507		20	251	251	334	4
5	Handrails	2006	3,308		20	165	165	303	5
6	Need Invoice	2006	286		20	29	29	45	6
7	Electric Magnet Door Holders	2006	988		20	99	99	165	7
8	1700 Feet Oak Chair Rail	2006	2,662		20	133	133	200	8
9	2 Elevator Controls Duplex Hydro Soft Start	2006	5,378		20	538	538	941	9
10	Heating And Cooling Equipment Including Ducts	2006	1,749		20	175	175	248	10
11	10 Touchbar Von Dupin Exit Devices	2006	5,100		20	510	510	850	11
12	Foundation Work	2006	4,500		20	450	450	525	12
13	Plywood For Dialysis Unit	2006	1,333		20	133	133	156	13
14	Tile For Dialysis Unit	2006	1,175		20	78	78	98	14
15	Electrical Work For Dialysis Unit	2006	9,950		20	995	995	1,161	15
16	Plumbing Work For Dialysis Unit	2006	23,000		20	2,300	2,300	2,683	16
17	Paint	2006	2,976		20	149	149	161	17
18	Oak Chair Rail	2006	871		20	44	44	47	18
19	Security System	2006	1,137		20	57	57	114	19
20	Wiring	2006	1,226		20	61	61	123	20
21	Security System	2006	1,847		20	92	92	177	21
22	Exit Doors Alarm System	2006	957		20	48	48	88	22
23	Screen, Lint With Snap	2007	119		20	6	6	6	23
24	Duplex Receptacles	2007	650		20	33	33	33	24
25	Universal Wide Style Handrail	2007	3,458		20	72	72	72	25
26	Furnish Hardware - Audio And Video Cable	2007	2,500		20	208	208	208	26
27	Duro Last Roofing System	2007	17,750		20	1,331	1,331	1,331	27
28	Compressor	2007	16,445		20	1,096	1,096	1,096	28
29	Fire Alram (Repair)	2007	4,364		20	364	364	364	29
30	Smoke Detector And Alarm	2007	1,293		20	65	65	65	30
31	Waterflow Labor/Pipe Fitting Fire Alram	2007	3,940		20	328	328	328	31
32	Walkway	2007	5,500		20	229	229	229	32
33	Renovated Parking Lot	2007	6,800		20	227	227	227	33
34	TOTAL (lines 1 thru 33)		\$ 5,262,123	\$ 432,238		\$ 234,443	\$ (197,795)	\$ 2,504,692	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 5,262,123	\$ 432,238		\$ 234,443	\$ (197,795)	\$ 2,504,692	1
2	Fire Alarm Control Panel	2007	9,252		20	441	441	441	2
3	2 Ccd Cameras	2007	1,853		20	93	93	93	3
4	Duro Lasting Roof Work	2007	17,750		20	1,775	1,775	1,775	4
5	Bristol/Modules For Chiller	2007	5,832		20	259	259	259	5
6	Compresor Replacer	2007	2,823		20	78	78	78	6
7	Elevator Work	2007	2,049		20	141	141	141	7
8	Doors	2007	1,425		20	71	71	71	8
9	Generator Repair	2007	2,721		20	136	136	136	9
10									10
11									11
12									12
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	1
2									2
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4									4
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	1
2									2
3									3
4									4
5									5
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Jackson Square Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	1
2									2
3									3
4									4
5									5
6									6
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	1
2									2
3									3
4									4
5									5
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33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	1
2									2
3									3
4									4
5									5
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33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	1
2									2
3									3
4									4
5									5
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Jackson Square Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	1
2									2
3									3
4									4
5									5
6									6
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	1
2									2
3									3
4									4
5									5
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	1
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4									4
5									5
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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)		\$ 5,305,828	\$ 432,238		\$ 237,437	\$ (194,801)	\$ 2,507,686	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	234		1987	1980	\$ 3,173,042	\$ 227,071		\$ 95,250	\$ (131,821)	\$ 1,810,437	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Alarm Service on Doors		2004	1,502		20	215	215	715	9
10		Video Recorder Monitor System		2004	1,766		20	252	252	841	10
11		Data Cables		2004	1,223		20	122	122	397	11
12		Control Panel		2004	865		20	58	58	187	12
13		Extending Vents		2004	1,255		20	126	126	408	13
14		Celling Fixtures, Monitoring System		2004	873		20	87	87	276	14
15		Front Door Locking System		2004	869		20	124	124	393	15
16		Paging System		2004	3,293		20	470	470	1,450	16
17		Light Fixtures		2005	1,190		20	119	119	357	17
18		Light Fixtures		2005	1,190		20	119	119	357	18
19		Light Fixtures		2005	1,233		20	123	123	370	19
20		Light Fixtures		2005	808		20	81	81	229	20
21		Light Fixtures		2005	1,133		20	113	113	312	21
22		Light Fixtures		2005	850		20	85	85	220	22
23		Light Fixtures		2005	1,133		20	113	113	293	23
24		Light Fixtures		2005	1,180		20	118	118	325	24
25		Block Heater on Generator		2005	1,327		20	190	190	490	25
26		Celling Tiles		2005	650		20	33	33	87	26
27		Celling Tiles		2005	28,859		20	1,443	1,443	3,487	27
28		Boiler		2005	5,364		20	447	447	1,341	28
29		Water Pump		2005	3,246		20	325	325	866	29
30		Cabling and Phone Upgrades		2005	8,262		20	826	826	1,721	30
31		Plumbing Work		2005	678		20	68	68	198	31
32		Generator Work		2005	1,248		20	125	125	354	32
33		Data Cables		2005	1,040		20	104	104	269	33
34		Fire System Work		2005	1,670		20	239	239	616	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	\$ 3,245,749	\$ 227,071		\$ 101,375	\$ (125,696)	\$ 1,826,996	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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 Avenue, LLC		2004	2004	\$ 128,077	\$ 3,284	35	\$ 3,659	\$ 375	\$ 15,095	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10	Alloc. - 7257 N. Lincoln Avenue, LLC			2005	11,676	1,498	20	754	(744)	1,741	10
11	Alloc. - 7257 N. Lincoln Avenue, LLC			2004	2,545	293	20	127	(166)	445	11
12											12
13	Alloc. -Nucare Services Corp.			2003	1,042	38	20	52	14	215	13
14	Alloc. -Nucare Services Corp.			2004	21,151	772	20	1,059	287	3,928	14
15	Alloc. -Nucare Services Corp.			2005	1,254	46	20	63	17	179	15
16	Alloc. -Nucare Services Corp.			2006	1,700	62	20	85	23	116	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	\$	167,445	\$	5,993	\$	5,799	\$	(194)	\$	21,719	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 Nursing & Rehab Ctr # 0039834 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 1,050,718	\$ 5,577	\$ 127,033	\$ 121,456	10	\$ 713,968	71
72	Current Year Purchases	65,703	494	7,026	6,532	10	7,026	72
73	Fully Depreciated Assets	109,247		70	70	10	109,247	73
74								74
75	TOTALS	\$ 1,225,668	\$ 6,071	\$ 134,129	\$ 128,058		\$ 830,241	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)	\$ 6,619,628	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 438,309	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 371,566	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (66,743)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,337,927	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	\$ 1,118	\$ 8,801	86
87	WATER FAUCETS - 2001	1,361	136	856	87
88	RESURFACE PK LOT/SIDEWALK - 2001	2,778			88
89					89
90					90
91	TOTALS	\$ 20,903	\$ 1,254	\$ 9,657	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	Alloc. From Nucare				511			5
6								6
7	TOTAL				\$ 511			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 8,134 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	Alloc. From Nucare		\$	\$ 2,874	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,874	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	\$		\$ 242,090	\$		\$ 242,090	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			83,872			83,872	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			241,818			241,818	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 prescrpts			340,322	50,686		391,008	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			4,308		66,357	141,125		211,790	13
14	TOTAL			\$ 4,308		\$ 974,459	\$ 191,811		\$ 1,170,578	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 Nursing & Rehab Ctr # 0039834 Report Period Beginning: 01/01/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (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	\$ 259,878	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,939,301	3,004,343	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,114	138,929	6
7	Other Prepaid Expenses	20,768	20,768	7
8	Accounts Receivable (owners or related parties)	(323,485)	(323,485)	8
9	Other(specify): <u>See Attached Schedule</u>	12,569	719,307	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,723,653	\$ 3,819,740	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	1,549,628	6,046,752	15
16	Equipment, at Historical Cost	1,057,013	1,575,064	16
17	Accumulated Depreciation (book methods)	(1,556,629)	(4,959,124)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		189,403	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)	\$ 1,104,092	\$ 7,128,370	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,827,745	\$ 10,948,110	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 30,849	\$ 30,849	26
27	Officer's Accounts Payable		198,244	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,100,000	2,100,000	29
30	Accrued Salaries Payable	441,305	441,305	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,765	25,765	31
32	Accrued Real Estate Taxes(Sch.IX-B)		284,820	32
33	Accrued Interest Payable		53,892	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	22,092	22,092	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	130,053	130,053	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,750,064	\$ 3,287,020	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,630,975	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)	\$	\$ 12,630,975	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,750,064	\$ 15,917,995	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,077,681	\$ (4,969,885)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,827,745	\$ 10,948,110	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,365,080	1
2	Restatements (describe):		2
3	Adjustment to Medicare bad Debts Receivable	(30,970)	3
4	Adjustment to S&E Medical Accrual	(79,837)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,254,273	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(176,592)	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)	\$ (176,592)	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)	\$ 1,077,681	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr

0039834

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 10,359,607	1
2	Discounts and Allowances for all Levels	(390,924)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,968,683	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,666,090	6
7	Oxygen	3,270	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,669,360	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	134,475	16
17	Sale of Drugs	620,979	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	58,676	19
20	Radiology and X-Ray	15,256	20
21	Other Medical Services	106,933	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 936,319	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,054	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,054	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	3,736	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,736	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,590,152	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,032,202	31
32	Health Care	4,213,478	32
33	General Administration	2,848,791	33
B. Capital Expense			
34	Ownership	2,278,772	34
C. Ancillary Expense			
35	Special Cost Centers	1,265,386	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)*	\$ 12,766,744	40
41	Income before Income Taxes (line 30 minus line 40)**	(176,592)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (176,592)	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 Nursing & Rehab Ctr

0039834

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,373	2,454	\$ 110,299	\$ 44.95	1
2	Assistant Director of Nursing	1,873	2,000	70,081	35.04	2
3	Registered Nurses	21,923	24,088	704,513	29.25	3
4	Licensed Practical Nurses	48,911	52,971	1,262,598	23.84	4
5	CNAs & Orderlies	123,203	134,375	1,366,180	10.17	5
6	CNA Trainees					6
7	Licensed Therapist	200	200	4,308	21.54	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,846	2,086	30,753	14.74	9
10	Activity Assistants	4,980	5,522	55,815	10.11	10
11	Social Service Workers	7,234	8,041	134,971	16.79	11
12	Dietician	3,440	3,874	68,951	17.80	12
13	Food Service Supervisor					13
14	Head Cook	4,929	5,568	56,056	10.07	14
15	Cook Helpers/Assistants	19,973	22,493	203,604	9.05	15
16	Dishwashers					16
17	Maintenance Workers	3,689	4,098	81,446	19.87	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,369	1,486	24,248	16.32	20
21	Assistant Administrator	1,965	2,086	75,824	36.35	21
22	Other Administrative	808	808	59,801	74.01	22
23	Office Manager					23
24	Clerical	20,035	22,919	249,520	10.89	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	4,461	4,887	109,791	22.47	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,191	3,448	94,808	27.50	33
34	TOTAL (lines 1 - 33)	276,403	303,404	\$ 4,763,567 *	\$ 15.70	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	292	\$ 12,254	01-03	35
36	Medical Director	Monthly	43,200	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	6,063	10-03	38
39	Pharmacist Consultant	Monthly	3,763	10-03	39
40	Physical Therapy Consultant	70	5,307	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	1,444	11-03	44
45	Social Service Consultant	54	2,916	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	442	\$ 79,171		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	604	21,326	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	604	\$ 21,326		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nursing & Rehab Ctr

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC-\$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. \$ 43,835 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. \$ 18,670 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT