

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0039834</u></p> <p>Facility Name: <u>Jackson Square Skl Nrsg & Living</u></p> <p>Address: <u>5130 West Jackson Boulevard</u> <u>Chicago</u> <u>60644</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 921-8000</u> Fax # <u>(773) 921-3980</u></p> <p>HFS ID Number: <u>363961688001</u></p> <p>Date of Initial License for Current Owners: <u>7/1/1994</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/09</u> to <u>12/31/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> <td></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u>			(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>			(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skl Nrsng & Living

0039834 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF	<u>59,539</u>	<u>1,219</u>	<u>12,026</u>	<u>72,784</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>59,539</u>	<u>1,219</u>	<u>12,026</u>	<u>72,784</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.22%

D. How many bed-hold days during this year were paid by the Department? 21 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 234 and days of care provided 8,611

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: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Jackson Square Skl Nrsng & Living # 0039834 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	364,839	108,248	13,680	486,767		486,767		486,767		1
2	Food Purchase		338,465		338,465	(17,706)	320,759	(3,314)	317,445		2
3	Housekeeping		47,536	413,779	461,315		461,315		461,315		3
4	Laundry		11,558		11,558		11,558		11,558		4
5	Heat and Other Utilities			312,445	312,445		312,445	(27,340)	285,105		5
6	Maintenance	87,451	84,533	216,097	388,081		388,081	(2,773)	385,308		6
7	Other (specify):*										7
8	TOTAL General Services	452,290	590,340	956,001	1,998,631	(17,706)	1,980,925	(33,426)	1,947,499		8
	B. Health Care and Programs										
9	Medical Director			42,950	42,950		42,950		42,950		9
10	Nursing and Medical Records	3,663,894	360,845	21,596	4,046,335		4,046,335	(691)	4,045,644		10
10a	Therapy										10a
11	Activities	84,966	12,821	1,820	99,607		99,607		99,607		11
12	Social Services	140,950		2,744	143,694		143,694		143,694		12
13	CNA Training										13
14	Program Transportation			16,110	16,110		16,110		16,110		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,889,810	373,666	85,220	4,348,696		4,348,696	(691)	4,348,005		16
	C. General Administration										
17	Administrative	140,856		930,392	1,071,248		1,071,248	(912,263)	158,985		17
18	Directors Fees										18
19	Professional Services			177,043	177,043	(1,692)	175,351	(9,232)	166,119		19
20	Dues, Fees, Subscriptions & Promotions			107,741	107,741		107,741	(77,711)	30,030		20
21	Clerical & General Office Expenses	281,734	39,229	273,719	594,682		594,682	(53,112)	541,570		21
22	Employee Benefits & Payroll Taxes			869,883	869,883	17,706	887,589		887,589		22
23	Inservice Training & Education			2,852	2,852		2,852		2,852		23
24	Travel and Seminar			4,501	4,501		4,501	(2,233)	2,268		24
25	Other Admin. Staff Transportation			169	169		169	1,102	1,271		25
26	Insurance-Prop.Liab.Malpractice			516,975	516,975		516,975	19,857	536,832		26
27	Other (specify):*							41,178	41,178		27
28	TOTAL General Administration	422,590	39,229	2,883,275	3,345,094	16,014	3,361,108	(992,413)	2,368,695		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,764,690	1,003,235	3,924,496	9,692,421	(1,692)	9,690,729	(1,026,530)	8,664,199		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 Skl Nrsng & Living

#0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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			180,867	180,867		180,867	170,894	351,761			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,196	42,196		42,196	638,692	680,888			32
33	Real Estate Taxes					1,692	1,692	261,230	262,922			33
34	Rent-Facility & Grounds			2,088,558	2,088,558		2,088,558	(2,088,130)	428			34
35	Rent-Equipment & Vehicles			10,513	10,513		10,513	3,683	14,196			35
36	Other (specify):*							61,883	61,883			36
37	TOTAL Ownership			2,322,134	2,322,134	1,692	2,323,826	(951,747)	1,372,079			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	12,977	500,941	884,362	1,398,280		1,398,280		1,398,280			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):*	106,545		425,009	531,554		531,554	(531,554)				43
44	TOTAL Special Cost Centers	119,522	500,941	1,437,486	2,057,949		2,057,949	(531,554)	1,526,395			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,884,212	1,504,176	7,684,116	14,072,504		14,072,504	(2,509,831)	11,562,673			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		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	(6,828)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(107,593)	30		9
10	Interest and Other Investment Income	(46)	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	(11,395)	20		18
19	Entertainment	(1,896)	24		19
20	Contributions	(18,210)	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	(194,741)	21		24
25	Fund Raising, Advertising and Promotional	(41,633)	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	(838,070)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,220,469)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,289,363)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,289,363)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,509,831)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Jackson Square Skl Nrsng & LivingID# 0039834Report Period Beginning: 01/01/09Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Food Rebates	\$ (3,257)	02	1
2	Copy Income	(348)	10	2
3	Rental Income	(220)	06	3
4	Jury Duty	(120)	21	4
5	Veterans Expense	(10,891)	10	5
6	Patient Needs	(8,999)	10	6
7	Patient Clothing	(4,361)	10	7
8	Bank Charges	(18,724)	21	8
9	Annual Report	(225)	20	9
10	Marketing Travel	(9)	43	10
11	Non-allowable Legal Fees	(12,155)	19	11
12	COPE Dues	(7,310)	20	12
13	Inservice Fee	(1,078)	24	13
14				14
15	Building Co:			15
16	Professional Fees	(10,666)	19	16
17	Bank Charges	(1,084)	21	17
18	Amortization	(5,965)	36	18
19	Misc. Licenses & Taxes	(4,702)	20	19
20				20
21	Guest Services	(51,702)	43	21
22	Marketing Salaries	(54,843)	43	22
23	Clinic Allocation- Real Estate	(20,329)	33	23
24	Clinic Allocation- Utilities	(22,922)	05	24
25	Non-Care Depreciation	(1,184)	30	25
26	Non-Allowable Settlement	(425,000)	43	26
27	Additional R & M	4,546	06	27
28	Quest- Administrative Fees	(160,201)	17	28
29	Capitalized R&M	(16,320)	06	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(838,070)		49

Jackson Square Skl Nrsg & Living

ID# 0039834

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
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76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
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90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jackson Square Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(3,314)											(3,314)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(29,750)		2,410									(27,340)	5
6	Maintenance	(11,994)	1,160	8,061									(2,773)	6
7	Other (specify):*													7
8	TOTAL General Services	(45,058)	1,160	10,471									(33,426)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(24,599)			23,908								(691)	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	(24,599)			23,908								(691)	16
	C. General Administration													
17	Administrative	(160,201)		(693,383)	(58,679)								(912,263)	17
18	Directors Fees													18
19	Professional Services	(22,821)	10,666	2,660	264								(9,232)	19
20	Fees, Subscriptions & Promotions	(83,475)	4,702	942	121								(77,711)	20
21	Clerical & General Office Expenses	(214,669)	1,084	145,134	15,339								(53,112)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,974)		592	149								(2,233)	24
25	Other Admin. Staff Transportation			579	523								1,102	25
26	Insurance-Prop.Liab.Malpractice		17,565	2,292									19,857	26
27	Other (specify):*			34,987	6,191								41,178	27
28	TOTAL General Administration	(484,140)	34,017	(506,197)	(36,092)								(992,413)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(553,797)	35,177	(495,726)	(12,184)								(1,026,530)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jackson Square Skl Nrsg & Living# 0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(108,777)	270,949	8,552	171								170,894	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(46)	633,422	5,037	280								638,692	32
33	Real Estate Taxes	(20,329)	273,881	7,678									261,230	33
34	Rent-Facility & Grounds		(2,088,558)	428									(2,088,130)	34
35	Rent-Equipment & Vehicles			3,683									3,683	35
36	Other (specify):*	(5,965)	67,848										61,883	36
37	TOTAL Ownership	(135,117)	(842,458)	25,378	450								(951,747)	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):*	(531,554)											(531,554)	43
44	TOTAL Special Cost Centers	(531,554)											(531,554)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,220,469)	(807,281)	(470,348)	(11,734)								(2,509,831)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 2,088,558	Jackson Square Associates	100.00%	\$	(2,088,558)	1
2	V	32 Interest	293	Jackson Square Associates	100.00%	633,715	633,422	2
3	V	19 Professional Fees		Jackson Square Associates	100.00%	10,666	10,666	3
4	V	21 Bank Fees		Jackson Square Associates	100.00%	1,084	1,084	4
5	V	30 Depreciation		Jackson Square Associates	100.00%	270,949	270,949	5
6	V	36 Amortization		Jackson Square Associates	100.00%	5,965	5,965	6
7	V	33 Real Estate Taxes		Jackson Square Associates	100.00%	273,881	273,881	7
8	V	26 Property & Liability Insurance		Jackson Square Associates	100.00%	17,565	17,565	8
9	V	20 Misc. Licenses & Taxes		Jackson Square Associates	100.00%	4,702	4,702	9
10	V	36 MIP Expense		Jackson Square Associates	100.00%	61,883	61,883	10
11	V	06 R&M		Jackson Square Associates	100.00%	1,160	1,160	11
12	V							12
13	V							13
14	Total		\$ 2,088,851			\$ 1,281,570	\$ * (807,281)	14

* 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	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,410	\$ 2,410
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	8,061	8,061
17	V	17 ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	18,129	18,129
18	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	2,660	2,660
19	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	942	942
20	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	145,134	145,134
21	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	592	592
22	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	579	579
23	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	2,292	2,292
24	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	34,987	34,987
25	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	8,552	8,552
26	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	5,037	5,037
27	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	7,678	7,678
28	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	428	428
29	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	3,683	3,683
30	V						
31	V	17 ADMINISTRATIVE FEES	711,512	NUCARE SERVICES CORP.			(711,512)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 711,512			\$ 241,164	\$ * (470,348)

* 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	10 CLINICAL SALARIES	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 23,908	\$	23,908	15
16	V	19 PROFESSIONAL FEES				264		264	16
17	V	20 DUES, LICENSE & INSPECTION				121		121	17
18	V	21 OFFICE WAGES				14,385		14,385	18
19	V	21 OFFICE EXPENSE				954		954	19
20	V	24 CONTINUING EDUCATION / SEMINAR				149		149	20
21	V	25 AUTO EXPENSE				523		523	21
22	V	27 PAYROLL TAXES				2,657		2,657	22
23	V	27 OTHER EMPLOYEE BENEFITS				3,534		3,534	23
24	V	30 DEPRECIATION				171		171	24
25	V	32 INTEREST				280		280	25
26	V								26
27	V	17 ADMINISTRATIVE FEES	58,679	CLINICAL CONSULTING SERVICES, LLC				(58,679)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 58,679			\$ 46,945	\$ *	(11,734)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

Facility Name & ID Number Jackson Square Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Hartman	Relative	Administrative	0.00%	See Attached	2.79	6.98%		\$	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,224,940	13	\$ 34,570	\$ 85,410	\$ 2,410	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,224,940	13	115,610	85,410	8,061	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,224,940	13	260,001	260,001	18,129	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,224,940	13	38,148	85,410	2,660	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,224,940	13	13,506	85,410	942	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,224,940	13	2,081,498	1,811,576	145,134	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,224,940	13	8,486	85,410	592	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,224,940	13	8,304	85,410	579	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,224,940	13	32,870	85,410	2,292	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,224,940	13	501,784	85,410	34,987	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,224,940	13	122,648	85,410	8,552	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,224,940	13	72,233	85,410	5,037	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,224,940	13	110,113	85,410	7,678	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,224,940	13	6,145	85,410	428	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,224,940	13	52,826	85,410	3,683	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,458,744	\$ 2,071,577	\$ 241,164	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skl Nrsng & Living

0039834

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	13	\$ 342,887	\$ 342,887	85,410	\$ 23,908	1
2	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	13	3,780		85,410	264	2
3	20	DUES, LICENSE & INSPECTIO	AVAIL. CENSUS DAYS	13	1,732		85,410	121	3
4	21	OFFICE WAGES	AVAIL. CENSUS DAYS	13	206,311	206,311	85,410	14,385	4
5	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	13	13,685		85,410	954	5
6	24	CONTINUING EDUCATION / ST	AVAIL. CENSUS DAYS	13	2,134		85,410	149	6
7	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	13	7,503		85,410	523	7
8	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	13	38,113		85,410	2,657	8
9	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	13	50,678		85,410	3,534	9
10	30	DEPRECIATION	AVAIL. CENSUS DAYS	13	2,448		85,410	171	10
11	32	INTEREST	AVAIL. CENSUS DAYS	13	4,013		85,410	280	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				\$ 673,284	\$ 549,198		\$ 46,946	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Skl Nrsng & Living # 0039834 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Skl Nrsng & Living # 0039834 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Skl Nrsng & Living

0039834 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Skl Nrsg & Living # 0039834 Report Period Beginning: 01/01/09 Ending: 12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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					\$	12,298,361		\$	633,715	1						
2													2						
3													3						
4													4						
5	See Supplemental Schedule												5						
Working Capital																			
6	Shareholder Loan		X	Working Capital					2,100,000			42,196	6						
7	Allocated- NuCare Services											5,037	7						
8	See Supplemental Schedule											280	8						
9	TOTAL Facility Related							\$	14,398,361		\$	681,228	9						
B. Non-Facility Related*																			
10	Interest Income		X									(46)	10						
11	Interest Income- Bldg. Co.		X									(293)	11						
12													12						
13	See Supplemental Schedule												13						
14	TOTAL Non-Facility Related							\$			\$	(339)	14						
15	TOTALS (line 9+line14)							\$	14,398,361		\$	680,889	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 61,883 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 Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8	Allocated- Clinical Consulting									280										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									280										
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									20										

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Jackson Square Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	89,364	1987	\$ 71,619	1
2	Allocation- 2757 N. Lincoln			10,599	2
3	TOTALS	89,364		\$ 82,218	3

SEE ACCOUNTANTS' COMPILATION REPORT

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1987	198,972		20			68,812
10	Various		1988	17,097		20			6,767
11	Various		1989	19,023		20	872	872	8,482
12	Various		1990	33,869		20	1,693	1,693	15,241
13	Various		1991	10,518		20	526	526	4,733
14	Various		1993	3,315		20	166	166	1,492
15	Various		1994	110,244		20	5,512	5,512	51,621
16	Various		1995	57,890		20	2,896	2,896	42,056
17	Various		1996	131,988		20	6,601	6,601	89,118
18	Various		1997	126,299		20	6,221	6,221	78,738
19	Various		1998	35,115		20	1,756	1,756	20,241
20	Various		1999	67,125		20	3,359	3,359	35,246
21	Various		2000	182,497		20	9,126	9,126	90,339
22	Various		2001	24,742		20	1,237	1,237	10,577
23	Various		2002	118,181		20	11,821	11,821	89,141
24	Various		2003	108,882		20	10,336	10,336	69,759
25	Various		2004	9,849		20	971	971	5,531
26	Various		2005	170,025		20	14,504	14,504	63,640
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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	Related Building Company (Pages 12F & 12G)	3,557,910	270,949		114,493	(156,456)	2,061,173	67
68	Related Party Allocations (Pages 12H & 12I)	127,590	3,962		4,601	639	26,127	68
69	Financial Statement Depreciation		179,683			(179,683)		69
70	TOTAL (lines 4 thru 69)	\$ 5,111,131	\$ 454,594		\$ 196,691	\$ (257,903)	\$ 2,838,834	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 Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 5,111,131	\$ 454,594		\$ 196,691	\$ (257,903)	\$ 2,838,834	1
2	Doors For Elevators	2006	5,260		20	263	263	1,052	2
3	Pergola	2006	1,250		20	125	125	500	3
4	Tiles Excelon Imp Textur	2006	1,312		20	87	87	350	4
5	Tiles Excelon Imp Textur	2006	1,698		20	113	113	453	5
6	Light Fixtures	2006	1,395		20	140	140	558	6
7	Interior Design Services	2006	1,185		20	119	119	464	7
8	Wall Covering	2006	3,690		20	738	738	2,891	8
9	Paint Hallway Walls	2006	1,250		20	125	125	490	9
10	Elevator Lighting	2006	850		20	85	85	340	10
11	Tiles Exelon Imp Textur	2006	1,012		20	67	67	264	11
12	Tiles Exelon Imp Textur	2006	1,892		20	126	126	473	12
13	Smoke Dampers	2006	1,171		20	167	167	627	13
14	CI Series Pump	2006	3,729		20	373	373	1,398	14
15	Water Booster Compact	2006	1,914		20	191	191	718	15
16	Wall Covering	2006	1,060		20	212	212	795	16
17	Window Treatment	2006	4,775		20	478	478	1,830	17
18	Windows	2006	5,436		20	544	544	1,993	18
19	Windows	2006	5,436		20	544	544	1,993	19
20	Wall Covering	2006	1,864		20	373	373	1,367	20
21	Smoke Detectors	2006	1,170		20	167	167	613	21
22	Bronze Anodized Finish Medium Stile Aluminum Door	2006	10,450		20	1,045	1,045	3,832	22
23	Insulated Windows	2006	13,796		20	1,380	1,380	5,059	23
24	Insulated Windows	2006	13,796		20	1,380	1,380	5,059	24
25	Excelon Imp Textur	2006	410		20	27	27	98	25
26	Water Heater	2006	11,525		20	960	960	3,522	26
27	Latex Paint	2006	311		20			311	27
28	Chair Rail	2006	360		20	18	18	66	28
29	Chair Rail	2006	3,307		20	165	165	593	29
30	New Roof	2006	67,500		20	6,750	6,750	24,188	30
31	Marathon Ac Motor	2006	1,056		20	106	106	387	31
32	Wallcovering	2006	2,638		20	528	528	1,935	32
33	Wallcovering	2006	5,265		20	1,053	1,053	3,773	33
34	TOTAL (lines 1 thru 33)		\$ 5,288,894	\$ 454,594		\$ 215,140	\$ (239,454)	\$ 2,906,826	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 Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 5,288,894	\$ 454,594		\$ 215,140	\$ (239,454)	\$ 2,906,826	1
2	Handrails	2006	3,689		20	184	184	661	2
3	Handrails	2006	3,693		20	185	185	662	3
4	Watermark Moire Buttermilk	2006	6,206		20	621	621	2,224	4
5	Johnsonite Cove Base	2006	4,632		20	463	463	1,698	5
6	Johnsonite Covebase	2006	751		20	75	75	269	6
7	Excelon Imp Textur Tile	2006	652		20	43	43	156	7
8	Repair And Paint Walls, Install Chair Rails And Basecove	2006	20,900		20	2,090	2,090	7,489	8
9	Repair And Wallpaper Walls, Install Chair Rails And Basecove	2006	24,000		20	2,400	2,400	8,600	9
10	Cubicle Curtains	2006	27,374		20	2,737	2,737	9,809	10
11	Electric Magnet Door Holders	2006	1,064		20	106	106	390	11
12	Electric Magnet Door Holders	2006	1,021		20	102	102	374	12
13	Electric Magnet Door Holders	2006	1,610		20	161	161	590	13
14	100 5-Gal Hd Clear	2006	522		20			522	14
15	Ceiling Tiles	2006	706		20	35	35	126	15
16	Plumbing To Replace Fittings And Pipe	2006	2,000		20	200	200	717	16
17	Plumbing To Replace Fittings And Pipe	2006	4,450		20	445	445	1,558	17
18	Handrails	2006	3,458		20	173	173	605	18
19	Insulated Glass	2006	537		20	54	54	197	19
20	Cement Curb	2006	2,800		20	187	187	622	20
21	Signage With Braille	2006	1,701		20	170	170	581	21
22	Recaulk All Openings At 3Rd Floor Therapy Rooms	2006	2,507		20	251	251	836	22
23	Handrails	2006	3,308		20	165	165	634	23
24	Need Invoice	2006	286		20	29	29	102	24
25	Electric Magnet Door Holders	2006	988		20	99	99	362	25
26	1700 Feet Oak Chair Rail	2006	2,662		20	133	133	466	26
27	2 Elevator Controls Duplex Hydro Soft Start	2006	5,378		20	538	538	2,017	27
28	Heating And Cooling Equipment Including Ducts	2006	1,749		20	175	175	598	28
29	10 Touchbar Von Dupin Exit Devices	2006	5,100		20	510	510	1,870	29
30	Foundation Work	2006	4,500		20	450	450	1,425	30
31	Plywood For Dialysis Unit	2006	1,333		20	133	133	422	31
32	Tile For Dialysis Unit	2006	1,175		20	78	78	255	32
33	Electrical Work For Dialysis Unit	2006	9,950		20	995	995	3,151	33
34	TOTAL (lines 1 thru 33)		\$ 5,439,596	\$ 454,594		\$ 229,127	\$ (225,467)	\$ 2,956,814	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 Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 5,439,596	\$ 454,594		\$ 229,127	\$ (225,467)	\$ 2,956,814	1
2	Plumbing Work For Dialysis Unit	2006	23,000		20	2,300	2,300	7,283	2
3	Paint	2006	2,976		20	149	149	459	3
4	Oak Chair Rail	2006	871		20	44	44	134	4
5	Security System	2006	1,137		20	57	57	227	5
6	Wiring	2006	1,226		20	61	61	245	6
7	Security System	2006	1,847		20	92	92	362	7
8	Exit Doors Alarm System	2006	957		20	48	48	183	8
9	Generator Repair	2007	2,721		20	272	272	612	9
10	Cabinets	2008	2,900		20	290	290	483	10
11	60 Yds. Covering For Admin'S Office	2009	7,254		20	6,463	6,463	6,463	11
12	Conference Room Remodel	2009	3,800		20	317	317	317	12
13	Cables From Generator Control Panel	2009	4,976		20	498	498	498	13
14	Sprinklers	2009	5,385		20	385	385	385	14
15	Refacing Doors. Bannister, And Nurses Station	2009	15,610		20	650	650	650	15
16	25 Cubicle Curtains	2009	2,793		20	70	70	70	16
17	60 Boxes Armstrong	2009	3,098		20	77	77	77	17
18	1 Trane Compressor	2009	8,204		20	364	364	364	18
19	First Q Digital Reset; 1 Passive Infared Sensor Door; Plastic Bump	2009	5,912		20	633	633	633	19
20	29 Indoor Cameras; 3 Outdoor Cameras; 32 Dvrs	2009	18,730		20	1,115	1,115	1,115	20
21	Chair Rails	2009	4,508		20	376	376	376	21
22	Architect Fees	2009	4,330		20	103	103	103	22
23	#34672 Flooring, Walls- Bathroom	2009	33,198		20	1,660	1,660	1,660	23
24	#34949 1St/2Nd Floor Wallcovering, Carpet	2009	26,686		20	1,334	1,334	1,334	24
25	#34954 Wall Covering/Guards	2009	2,682		20	134	134	134	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,624,397	\$ 454,594		\$ 246,620	\$ (207,974)	\$ 2,980,981	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	
1		\$ 5,624,397	\$ 454,594		\$ 246,620	\$ (207,974)	\$ 2,980,981	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)	\$ 5,624,397	\$ 454,594		\$ 246,620	\$ (207,974)	\$ 2,980,981	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 Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	Building Company Information								1
2	Buildings:								2
3		1980	3,173,042	270,949	39	95,250	(175,699)	2,000,937	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	11,647		20	582	582	5,831	9
10	Various	2005	61,061		20	3,053	3,053	17,998	10
11	Screen, Lint With Snap	2007	119		20	6	6	18	11
12	Duplex Receptacles	2007	650		20	33	33	98	12
13	Universal Wide Style Handrail	2007	3,458		20	173	173	519	13
14	Furnish Hardware - Audio And Video Cable	2007	2,500		20	125	125	375	14
15	Duro Last Roofing System	2007	17,750		20	888	888	2,663	15
16	Compressor	2007	16,445		20	822	822	2,467	16
17	Fire Alram (Repair)	2007	4,364		20	218	218	655	17
18	Smoke Detector And Alarm	2007	1,293		20	65	65	194	18
19	Waterflow Labor/Pipe Fitting Fire Alram	2007	3,940		20	197	197	591	19
20	Walkway	2007	5,500		20	275	275	825	20
21	Renovated Parking Lot	2007	6,800		20	340	340	1,020	21
22	Fire Alarm Control Panel	2007	9,252		20	463	463	1,388	22
23	2 Ccd Cameras	2007	1,853		20	93	93	278	23
24	Duro Lasting Roof Work	2007	17,750		20	888	888	2,663	24
25	Bristol/Modules For Chiller	2007	5,832		20	292	292	875	25
26	Compresor Replacer	2007	2,823		20	141	141	423	26
27	Elevator Work	2007	2,049		20	102	102	307	27
28	Doors	2007	1,425		20	71	71	214	28
29	Telephone System	2008	43,547		20	2,177	2,177	4,355	29
30	Digital Video Multiplexer Recorder, Color Dome Camera	2008	2,693		20	135	135	269	30
31	Elevator Car Doors	2008	3,875		20	194	194	388	31
32	Furnish and Install Insulated Glass Window	2008	25,820		20	1,291	1,291	2,582	32
33	Furnish and Install Solid Iron Fence	2008	4,860		20	243	243	486	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
TOTAL (12F & 12G lines 1 thru 33)		\$ 3,557,910	\$ 270,949		\$ 114,493	\$ (156,456)	\$ 2,061,173	

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated- 7257 N. Lincoln	2004	90,365	2,317	35	2,736	419	16,760	3
4	Allocated- Clinical Consulting Services	2004	5,020	129	35	143	14	879	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated- 7257 N. Lincoln	2005	8,238	652	20	532	(120)	2,292	9
10	Allocated- 7257 N. Lincoln	2004	1,796	103	20	90	(13)	494	10
11									11
12	Allocated- Clinical Consulting Services	2005	458	36	20	30	(6)	127	12
13	Allocated- Clinical Consulting Services	2004	100	6	20	5	(1)	27	13
14									14
15	Allocated- NuCare Services	2003	817	27	20	41	14	250	15
16	Allocated- NuCare Services	2004	16,581	552	20	830	278	4,739	16
17	Allocated- NuCare Services	2005	983	33	20	49	16	239	17
18	Allocated- NuCare Services	2006	1,333	44	20	67	23	224	18
19	Allocated- NuCare Services	2008	1,405	47	20	70	23	88	19
20	Allocated- NuCare Services	2009	494	16	20	8	(8)	8	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 127,590	\$ 3,962		\$ 4,601	\$ 639	\$ 26,127	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 Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 1,041,953	\$ 3,364	\$ 96,263	\$ 92,899	10	\$ 757,112	71
72	Current Year Purchases	92,531	1,396	8,342	6,946	10	8,342	72
73	Fully Depreciated Assets	257,396		536	536	10	257,396	73
74								74
75	TOTALS	\$ 1,391,880	\$ 4,760	\$ 105,141	\$ 100,381		\$ 1,022,850	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)	\$ 7,100,777	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 459,354	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 351,761	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (107,593)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,003,831	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	INSTALL NEW COMPRESS - 2000	\$ 16,764	\$ 838	\$ 8,312	86
87	WATER FAUCETS - 2001	1,361	68	567	87
88	RESURFACE PK LOT/SIDEWALK - 2001	2,778	278	2,037	88
89					89
90					90
91	TOTALS	\$ 20,903	\$ 1,184	\$ 10,916	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6	<u>Allocated- NuCare Services (Parking Lot)</u>				<u>428</u>			6
7	TOTAL				\$ <u>428</u>			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 14,196 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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		Contract	Total
		1 Drop-outs	2 Completed		
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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs					\$ 299,094							\$ 299,094	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					136,060							136,060	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					301,828							301,828	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescrpts							368,253					368,253	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): <u>See Supplemental</u>				12,977			147,380		132,688					293,045	13
14	TOTAL				\$ 12,977			\$ 884,362		\$ 500,941					\$ 1,398,280	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 Skl Nrsng & Living**

0039834

Report Period Beginning: **01/01/09**

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 3,028	\$ 311,847	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,759,069	2,824,111	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	130,393	187,625	6
7	Other Prepaid Expenses	251,199	251,199	7
8	Accounts Receivable (owners or related parties)	1,158,212	1,158,212	8
9	Other(specify): <u>See Attached Schedule</u>	57,459	398,809	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,359,360	\$ 5,131,803	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	1,631,900	6,399,896	15
16	Equipment, at Historical Cost	1,060,450	1,742,188	16
17	Accumulated Depreciation (book methods)	(1,932,412)	(5,845,431)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		177,473	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>	12,084	12,084	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 772,022	\$ 6,708,405	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,131,382	\$ 11,840,208	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,235,838	\$ 1,235,838	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	565,858	565,858	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,050	23,050	31
32	Accrued Real Estate Taxes(Sch.IX-B)		284,607	32
33	Accrued Interest Payable		52,723	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	21,980	21,980	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	1,099,153	1,104,196	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,045,879	\$ 5,586,496	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,298,361	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)	\$	\$ 12,298,361	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,045,879	\$ 17,884,857	46
47	TOTAL EQUITY(page 18, line 24)	\$ 85,503	\$ (6,044,649)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,131,382	\$ 11,840,208	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,131,094	1
2	Restatements (describe):		2
3	Bad Debt	(24,850)	3
4	Amortization of Good Will	(54,080)	4
5	Oxygen Supplies	34,234	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,086,398	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,000,895)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,000,895)	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)	\$ 85,503	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skl Nrsng & Living

0039834

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	\$ 10,953,788	1
2	Discounts and Allowances for all Levels	(232,659)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,721,129	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,549,588	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,549,588	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	51,825	16
17	Sale of Drugs	543,687	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,337	19
20	Radiology and X-Ray	8,320	20
21	Other Medical Services	167,409	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 789,578	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	46	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	11,268	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,268	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,071,609	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,998,631	31
32	Health Care	4,348,696	32
33	General Administration	3,345,094	33
B. Capital Expense			
34	Ownership	2,322,134	34
C. Ancillary Expense			
35	Special Cost Centers	1,929,834	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)*	\$ 14,072,504	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,000,895)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,000,895)	43

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

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

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

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

Facility Name & ID Number Jackson Square Skl Nrsg & Living

0039834

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,898	2,257	\$ 104,529	\$ 46.31	1
2	Assistant Director of Nursing	1,885	2,144	80,724	37.65	2
3	Registered Nurses	17,519	19,653	766,317	38.99	3
4	Licensed Practical Nurses	50,457	55,328	1,332,737	24.09	4
5	CNAs & Orderlies	108,470	120,159	1,309,208	10.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,431	2,431	33,418	13.75	9
10	Activity Assistants	4,245	4,850	51,548	10.63	10
11	Social Service Workers	10,755	11,854	140,950	11.89	11
12	Dietician	3,674	4,095	81,064	19.80	12
13	Food Service Supervisor					13
14	Head Cook	4,803	5,540	62,446	11.27	14
15	Cook Helpers/Assistants	19,518	22,197	221,329	9.97	15
16	Dishwashers					16
17	Maintenance Workers	3,926	4,231	87,451	20.67	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,981	2,086	87,630	42.01	20
21	Assistant Administrator					21
22	Other Administrative	2,402	2,459	53,226	21.65	22
23	Office Manager					23
24	Clerical	15,313	19,264	281,734	14.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,974	4,292	70,379	16.40	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,376	4,758	119,522	25.12	33
34	TOTAL (lines 1 - 33)	257,627	287,598	\$ 4,884,212 *	\$ 16.98	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	304	\$ 13,680	01-03	35
36	Medical Director	Monthly	42,950	09-03	36
37	Medical Records Consultant	Monthly	4,320	10-03	37
38	Nurse Consultant	355	7,029	10-03	38
39	Pharmacist Consultant	Monthly	3,595	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	1,820	11-03	44
45	Social Service Consultant	49	2,744	12-03	45
46	Other(specify)				46
47	Therapy Consultant				47
48					48
49	TOTAL (lines 35 - 48)	741	\$ 76,138		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	195	6,652	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	195	\$ 6,652		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skl Nrsg & Living

0039834

Report Period Beginning: 01/01/09

Ending: 12/31/09

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. II Assoc. of HC- \$2,808; ILCLTC- \$18,006
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,683 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 128,115
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? No
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 17,706 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.