

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686 Report Period Beginning: 01/01/15 Ending: 12/31/15

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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			<u>10,444</u>	<u>10,444</u>	8
9	SNF/PED					9
10	ICF	<u>61,884</u>	<u>5,238</u>	<u>2,579</u>	<u>69,701</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>61,884</u>	<u>5,238</u>	<u>13,023</u>	<u>80,145</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.84%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 234 and days of care provided 6,575

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	361,719	31,330	24,496	417,545		417,545		417,545		1
2	Food Purchase		456,264		456,264		456,264	(4,587)	451,677		2
3	Housekeeping		317,930		317,930		317,930		317,930		3
4	Laundry	27,342	172,430	24,117	223,889		223,889		223,889		4
5	Heat and Other Utilities			399,130	399,130		399,130	(4,375)	394,755		5
6	Maintenance	70,797		277,858	348,655		348,655	(45,529)	303,126		6
7	Other (specify):*							4,070	4,070		7
8	TOTAL General Services	459,858	977,954	725,601	2,163,413		2,163,413	(50,420)	2,112,993		8
	B. Health Care and Programs										
9	Medical Director			42,320	42,320		42,320		42,320		9
10	Nursing and Medical Records	4,228,221	513,748	59,453	4,801,422		4,801,422	266,225	5,067,647		10
10a	Therapy	62,846		58,759	121,605		121,605	(5,247)	116,358		10a
11	Activities	145,508	5,349	1,980	152,837		152,837	(21)	152,816		11
12	Social Services	193,916			193,916		193,916		193,916		12
13	CNA Training										13
14	Program Transportation			65,729	65,729		65,729	(582)	65,147		14
15	Other (specify):*							53,695	53,695		15
16	TOTAL Health Care and Programs	4,630,491	519,097	228,241	5,377,829		5,377,829	314,070	5,691,899		16
	C. General Administration										
17	Administrative	209,769		955,663	1,165,432		1,165,432	(896,730)	268,702		17
18	Directors Fees										18
19	Professional Services			179,171	179,171	(18,978)	160,193	90,565	250,758		19
20	Dues, Fees, Subscriptions & Promotions			68,983	68,983		68,983	(19,509)	49,474		20
21	Clerical & General Office Expenses	274,883	16,045	482,411	773,339		773,339	(129,084)	644,255		21
22	Employee Benefits & Payroll Taxes			1,167,461	1,167,461		1,167,461		1,167,461		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,596	8,596		8,596	2,708	11,304		24
25	Other Admin. Staff Transportation			4,644	4,644		4,644	13,610	18,254		25
26	Insurance-Prop.Liab.Malpractice			637,112	637,112		637,112	8,722	645,834		26
27	Other (specify):*							65,560	65,560		27
28	TOTAL General Administration	484,652	16,045	3,504,041	4,004,738	(18,978)	3,985,760	(864,157)	3,121,603		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,575,001	1,513,096	4,457,883	11,545,980	(18,978)	11,527,002	(600,507)	10,926,495		29

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

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

Facility Name & ID Number

Jackson Square Nrsg. & Rehab

#0053686

Report Period Beginning:

01/01/15

Ending:

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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			15,217	15,217		15,217	287,740	302,957			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							296,971	296,971			32
33	Real Estate Taxes			464,709	464,709	18,978	483,687	(34,506)	449,181			33
34	Rent-Facility & Grounds			1,212,949	1,212,949		1,212,949	(1,210,316)	2,633			34
35	Rent-Equipment & Vehicles			29,854	29,854		29,854	11,434	41,288			35
36	Other (specify):*			228	228		228	68,411	68,639			36
37	TOTAL Ownership			1,722,957	1,722,957	18,978	1,741,935	(580,265)	1,161,670			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		483,136	1,714,865	2,198,001		2,198,001	(11,280)	2,186,721			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			645,516	645,516		645,516		645,516			42
43	Other (specify):*	847		21,146	21,993		21,993	(21,993)	(0)			43
44	TOTAL Special Cost Centers	847	483,136	2,381,527	2,865,510		2,865,510	(33,273)	2,832,237			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,575,848	1,996,232	8,562,367	16,134,447		16,134,447	(1,214,046)	14,920,401			45

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

Facility Name & ID Number Jackson Square Nrsng. & Rehab

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Report Period Beginning:

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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	(8,558)	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	279,655	30		9
10	Interest and Other Investment Income	(5,061)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,289)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(298)	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	(49,322)	21		18
19	Entertainment				19
20	Contributions	(16,700)	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	(269,324)	21		24
25	Fund Raising, Advertising and Promotional	(5,034)	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	(751,889)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (830,820)		\$	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)	(383,226)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (383,226)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,214,046)		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		52	
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Jackson Square Nrsng. & Rehab

ID# 0053686

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration	\$ (94,135)	21	1
2	Veterans Expense	(3,938)	10	2
3	Rental Income	(54,666)	06	3
4	Marketing Director	(847)	43	4
5	Bank Charges	(23,303)	21	5
6	Marketing Services	(21,146)	43	6
7	Amortization	(228)	36	7
8	Additional R&M	7,197	06	8
9	Non-Allowable Legal	(5,164)	19	9
10	Building Co - Accounting	(13,885)	19	10
11	Building Co - Professional Fees	(5,600)	19	11
12	Building Co - Data Processing	(440)	19	12
13	Building Co - Closing Expense	(64,552)	36	13
14	Annual Report	(175)	20	14
15	PAC Dues	(9,946)	20	15
16	Clinic Allocation - Real Estate	(28,284)	33	16
17	Clinic Allocation - Utilities	(29,293)	06	17
18	Non-Care Depreciation	(2,849)	30	18
19	Rent for Sale/Leaseback Arrangement	(400,634)	34	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	(751,889)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	(4,587)											(4,587)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,558)		4,024	159								(4,375)	5
6	Maintenance	(76,762)		27,631	3,602								(45,529)	6
7	Other (specify):*			3,476	595								4,070	7
8	TOTAL General Services	(89,907)		35,131	4,356								(50,420)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,938)		242,763	27,668	(268)							266,225	10
10a	Therapy					(5,247)							(5,247)	10a
11	Activities					(21)							(21)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation						(582)						(582)	14
15	Other (specify):*			47,365	6,329								53,695	15
16	TOTAL Health Care and Programs	(3,938)		290,128	33,998	(5,536)	(582)						314,070	16
	C. General Administration													
17	Administrative			(673,113)	(223,617)								(896,730)	17
18	Directors Fees													18
19	Professional Services	(25,089)	19,925	89,909	5,820								90,565	19
20	Fees, Subscriptions & Promotions	(31,855)		9,231	3,115								(19,509)	20
21	Clerical & General Office Expenses	(436,084)	(270)	242,051	65,219								(129,084)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,298	1,757	(346)							2,708	24
25	Other Admin. Staff Transportation			12,951	659								13,610	25
26	Insurance-Prop.Liab.Malpractice		8,706	16									8,722	26
27	Other (specify):*			51,422	14,139								65,560	27
28	TOTAL General Administration	(493,028)	28,361	(266,235)	(132,908)	(346)							(864,157)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(586,874)	28,361	59,024	(94,554)	(5,882)	(582)						(600,507)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jackson Square Nrsg. & Rehab# 0053686

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	276,806		9,711	1,223								287,740	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,061)	298,356	3,515	161								296,971	32
33	Real Estate Taxes	(28,284)	(10,451)	3,521	708								(34,506)	33
34	Rent-Facility & Grounds	(400,634)	(812,315)	2,633									(1,210,316)	34
35	Rent-Equipment & Vehicles			9,168	2,267								11,434	35
36	Other (specify):*	(64,780)	133,191										68,411	36
37	TOTAL Ownership	(221,953)	(391,219)	28,547	4,359								(580,265)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(11,280)							(11,280)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(21,993)											(21,993)	43
44	TOTAL Special Cost Centers	(21,993)				(11,280)							(33,273)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(830,820)	(362,858)	87,571	(90,195)	(17,162)	(582)						(1,214,046)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 812,315	Jackson Square Associates	100.00%	\$	\$ (812,315)	1
2	V	33 Real Estate Taxes	312,491	Jackson Square Associates	100.00%	302,040	(10,451)	2
3	V	32 Interest	323	Jackson Square Associates	100.00%	298,679	298,356	3
4	V	19 Accounting		Jackson Square Associates	100.00%	13,885	13,885	4
5	V	19 Professional Fees - Other		Jackson Square Associates	100.00%	5,600	5,600	5
6	V	19 Data Processing		Jackson Square Associates	100.00%	440	440	6
7	V	21 Miscellaneous Administrative	270	Jackson Square Associates	100.00%		(270)	7
8	V	26 Property and Liability Insurance		Jackson Square Associates	100.00%	8,706	8,706	8
9	V	36 MIP Expense		Jackson Square Associates	100.00%	68,639	68,639	9
10	V	36 Closing Expenses		Jackson Square Associates	100.00%	64,552	64,552	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,125,399			\$ 762,541	\$ * (362,858)	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%	\$ 4,024	\$	4,024	15
16	V	6 MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	17,815		17,815	16
17	V	6 MAINTENANCE EXPENSES		NUCARE SERVICES CORP.	100.00%	9,816		9,816	17
18	V	7 EMPLOYEE BENEFITS - MAINTENANCE		NUCARE SERVICES CORP.	100.00%	3,476		3,476	18
19	V	10 CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	242,763		242,763	19
20	V	15 EMPLOYEE BENEFITS - CLINICAL		NUCARE SERVICES CORP.	100.00%	47,365		47,365	20
21	V	17 ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	54,847		54,847	21
22	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	89,909		89,909	22
23	V	20 DUES, FEES, SUBSCRIPTIONS, ETC.		NUCARE SERVICES CORP.	100.00%	9,231		9,231	23
24	V	21 CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	208,706		208,706	24
25	V	21 CLERICAL & GENERAL EXPENSES		NUCARE SERVICES CORP.	100.00%	33,345		33,345	25
26	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,298		1,298	26
27	V	25 TRANSPORTATION		NUCARE SERVICES CORP.	100.00%	12,951		12,951	27
28	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	16		16	28
29	V	27 EMPLOYEE BENEFITS - ADMINISTRATIVE		NUCARE SERVICES CORP.	100.00%	51,422		51,422	29
30	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	9,711		9,711	30
31	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	3,515		3,515	31
32	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	3,521		3,521	32
33	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	2,633		2,633	33
34	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	2,626		2,626	34
35	V	35 AUTO LEASE		NUCARE SERVICES CORP.	100.00%	6,541		6,541	35
36	V								36
37	V	17 BOOKKEEPING	727,960	NUCARE SERVICES CORP.	100.00%			(727,960)	37
38	V								38
39	Total		\$ 727,960			\$ 815,531	\$ *	87,571	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	5 UTILITIES	\$	MAESTRO CONSULTING SERVICES LLC	100.00%	\$ 159	\$	159	15
16	V	6 MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	2,597		2,597	16
17	V	6 MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	1,006		1,006	17
18	V	7 EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	595		595	18
19	V	10 CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	27,668		27,668	19
20	V	15 EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	6,329		6,329	20
21	V	17 ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	4,086		4,086	21
22	V	19 PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	5,820		5,820	22
23	V	20 DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	3,115		3,115	23
24	V	21 CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	61,700		61,700	24
25	V	21 CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	3,519		3,519	25
26	V	24 SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,757		1,757	26
27	V	25 TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	659		659	27
28	V	27 EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	14,139		14,139	28
29	V	30 DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,223		1,223	29
30	V	32 INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100.00%	161		161	30
31	V	33 REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	708		708	31
32	V	35 EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	1,622		1,622	32
33	V	35 AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	645		645	33
34	V								34
35	V	17 BOOKKEEPING	227,703	MAESTRO CONSULTING SERVICES LLC	100.00%			(227,703)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 227,703			\$ 137,508	\$ *	(90,195)	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	10 Nursing Supplies & Equipment	\$ 2,648	Integra Healthcare Equipment LLC		\$ 2,380	\$ (268)
16	V	10A Respiratory Services	51,797	Integra Healthcare Equipment LLC		46,550	(5,247)
17	V	11 Activity Expense	206	Integra Healthcare Equipment LLC		185	(21)
18	V	24 Seminar Expense	3,420	Integra Healthcare Equipment LLC		3,074	(346)
19	V	39 DME & Medical Supplies	111,359	Integra Healthcare Equipment LLC		100,079	(11,280)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 169,430			\$ 152,268	\$ * (17,162)

* 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	14 Transportation	\$ 7,600	Lifeline Ambulance LLC		\$ 7,018	\$ (582)	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		\$ 7,600			\$ 7,018	\$ *	(582) 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	22 Workers Compensation	\$ 21,699	Maple Leaf Insurance	100.00%	\$ 21,699	\$	15
16	V	26 Liability Insurance	11,036	Maple Leaf Insurance	100.00%	11,036		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		\$ 32,735			\$ 32,735	\$ *	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.

Facility Name & ID Number Jackson Square Nrsng. & Rehab # 0053686 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Michael Munter	Owner	Administrative	19.00%	See Attached	2.32	4.65%	Alloc Salary	\$ 4,086	17-7	1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 4,086		13	

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

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Jackson Square Nrsng. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	1,031,168	17	\$ 58,329	\$ 71,136	\$ 4,024	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,031,168	17	258,238	258,238	17,815	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,031,168	17	142,295	71,136	9,816	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,031,168	17	50,385	71,136	3,476	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,031,168	17	3,519,020	3,519,020	242,763	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,031,168	17	686,596	71,136	47,365	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,031,168	17	795,048	795,048	54,847	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,031,168	17	1,303,295	71,136	89,909	8
9	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,031,168	17	133,814	71,136	9,231	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,031,168	17	3,025,348	3,025,348	208,706	10
11	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,031,168	17	483,355	71,136	33,345	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,031,168	17	18,809	71,136	1,298	12
13	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,031,168	17	187,735	71,136	12,951	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	1,031,168	17	238	71,136	16	14
15	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,031,168	17	745,397	71,136	51,422	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,031,168	17	140,764	71,136	9,711	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,031,168	17	50,953	71,136	3,515	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,031,168	17	51,037	71,136	3,521	18
19	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,031,168	17	38,171	71,136	2,633	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,031,168	17	38,069	71,136	2,626	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,031,168	17	94,822	71,136	6,541	21
22									22
23									23
24									24
25	TOTALS					\$ 11,821,715	\$ 7,597,654	\$ 815,531	25

Facility Name & ID Number Jackson Square Nrsng. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 MAESTRO 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 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	307,257	28	\$ 3,424	\$ 14,274	\$ 159	1	
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	307,257	28	55,893	55,893	14,274	2,597	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	307,257	28	21,648	14,274	1,006	3	
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	307,257	28	12,799	14,274	595	4	
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	307,257	28	595,582	595,582	14,274	27,668	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	307,257	28	136,244	14,274	6,329	6	
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	307,257	28	87,954	2,420	14,274	4,086	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	307,257	28	125,288	14,274	5,820	8	
9	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	307,257	28	67,058	14,274	3,115	9	
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	307,257	28	1,328,131	1,328,131	14,274	61,700	10
11	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	307,257	28	75,756	14,274	3,519	11	
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	307,257	28	37,815	14,274	1,757	12	
13	25	TRANSPORTATION	AVAIL. CENSUS DAYS	307,257	28	14,185	14,274	659	13	
14	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	307,257	28	304,341	14,274	14,139	14	
15	30	DEPRECIATION	AVAIL. CENSUS DAYS	307,257	28	26,334	14,274	1,223	15	
16	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	307,257	28	3,464	14,274	161	16	
17	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	307,257	28	15,239	14,274	708	17	
18	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	307,257	28	34,911	14,274	1,622	18	
19	35	AUTO LEASE	AVAIL. CENSUS DAYS	307,257	28	13,885	14,274	645	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,959,951	\$ 1,982,025	\$ 137,508	25	

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

1	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	10	Nursing Supplies & Equipment	Direct Allocation		\$	\$		2,380	1
2	10A	Respiratory Services	Direct Allocation					46,550	2
3	11	Activity Expense	Direct Allocation					185	3
4	24	Seminar Expense	Direct Allocation					3,074	4
5	39	DME & Medical Supplies	Direct Allocation					100,079	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				\$	\$		152,268	25

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Lifeline Ambulance LLC

Street Address

2424 S. Wabash Avenue

City / State / Zip Code

Chicago, IL 60616

Phone Number

(312) 949-9595

Fax Number

(312) 949-9262

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.

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	14	Transportation	Direct Allocation		\$	\$		\$ 7,018	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				\$	\$		\$ 7,018	25

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Maple Leaf Insurance

Street Address

PO BOX 69,720 West Bay Rd.

City / State / Zip Code

Grand Cayman KY1-1102

Phone Number

()

Fax Number

()

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation		\$	\$		\$ 21,699	1
2	26	Liability Insurance	Direct Allocation					11,036	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				\$	\$		\$ 32,735	25

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number **Jackson Square Nrsg. & Rehab**

0053686 Report Period Beginning: **01/01/15** Ending: **12/31/15**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	The Private Bank		X	Note Payable			\$	\$ 981,134			\$	1								
2	HUD		X									298,679	2							
3													3							
4													4							
5													5							
	Working Capital																			
6	Allocated from NuCare Serv	X										3,515	6							
7	Allocated from Maestro Consult	X										161	7							
8													8							
9	TOTAL Facility Related						\$	\$ 981,134			\$	302,355	9							
	B. Non-Facility Related*																			
10	Interest Income		X									(5,061)	10							
11	Interest Income - Bldg Co		X									(323)	11							
12													12							
13													13							
14	TOTAL Non-Facility Related						\$	\$			\$	(5,384)	14							
15	TOTALS (line 9+line14)						\$	\$ 981,134			\$	296,971	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 68,639 Line # 36

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

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

Facility Name & ID Number

Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

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

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2014 report.		\$	388,161		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	353,069		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(35,092)		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	66,000		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	18,978		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 75,209 For 2010 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	49,886		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>304,857</u>	<u>8</u>	FOR BHF USE ONLY	
	2011	<u>305,520</u>	<u>9</u>	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012	<u>333,859</u>	<u>10</u>	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	<u>341,563</u>	<u>11</u>		
	2014	<u>348,840</u>	<u>12</u>		
The amount on line 7 does not agree to page 4, line 33. This is the result of the accrual on line 4 above being for only 2 months (calculated below):					
2015 Accrual: \$377,124 x 1.05 x 2/12 months = \$66,000				15	LESS REFUND FROM LINE 6 \$ 15
Allocated from NuCare Services Corp: \$3,521					
Allocated from Maestro Consulting Services: \$708				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

Facility Name & ID Number Jackson Square Nrsng. & Rehab

0053686 Report Period Beginning:

01/01/15 Ending:

12/31/15

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	<u>Facility</u>	<u>89,364</u>	<u>1987</u>	<u>\$ 71,619</u>	<u>1</u>
2	<u>Allocated from Nucare/Maestro 7257 N. Lincoln Ave</u>			<u>8,634</u>	<u>2</u>
3	TOTALS	89,364		\$ 80,253	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	234		1980	\$ 3,173,042	\$	39	\$ 81,360	\$ 81,360	\$ 2,502,987	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1987	198,972		20			68,812	9
10	Various		1988	17,097		20			6,767	10
11	Various		1989	19,023		20			8,482	11
12	Various		1990	33,869		20			16,793	12
13	Various		1991	10,518		20			5,741	13
14	Various		1993	3,315		20			2,141	14
15	Various		1994	110,244		20			78,640	15
16	Various		1995	57,890		20	1,359	1,359	57,884	16
17	Various		1996	131,988		20	6,599	6,599	128,713	17
18	Various		1997	126,299		20	6,220	6,220	116,061	18
19	Various		1998	35,115		20	1,756	1,756	30,777	19
20	Various		1999	67,125		20	3,356	3,356	55,382	20
21	Various		2000	182,497		20	9,125	9,125	145,088	21
22	Various		2001	24,742		20	1,237	1,237	18,000	22
23	Various		2002	119,751		20			119,751	23
24	Various		2003	107,313		20	989	989	103,194	24
25	Various		2004	9,849		20	76	76	9,595	25
26	Various		2005	170,025		20	7,682	7,682	121,871	26
27	Various		2006	347,480		20	30,759	30,759	312,048	27
28	Various		2007	2,721		20	272	272	2,245	28
29	Various		2008	2,900		20	290	290	2,223	29
30	Various		2009	136,688		20	12,108	12,108	93,681	30
31	Various		2010	35,779		20	2,601	2,601	22,003	31
32	Various		2011	350,322		20	34,853	34,853	165,932	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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		610,839			31,719	31,719	203,908	67
68		171,941	5,016		4,341	(675)	66,364	68
69			12,368			(12,368)		69
70		\$ 6,257,343	\$ 17,384		\$ 236,702	\$ 219,318	\$ 4,465,083	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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	\$ 6,257,343	\$ 17,384		\$ 236,702	\$ 219,318	\$ 4,465,083		1
2	Compressor For Trane A/C	2012 3,735		20	374	374	1,307		2
3	Door Levers	2012 4,114		20	411	411	1,268		3
4	Elevator Motor	2012 2,524		20	126	126	410		4
5	Sprinkler System-Replaced 4" Check Valve	2013 2,752		20	138	138	310		5
6	Skylight Glass Replacement	2014 7,380		20	738	738	1,230		6
7	Parking Lot Paving	2014 13,250		20	883	883	1,472		7
8	Fire Alarm System	2014 9,655		20	1,379	1,379	2,069		8
9	Electrical Outlets	2014 5,300		20	530	530	707		9
10	Plumbing-Replace P-Trap In Boiler Room, Replace Corridor Pipe	2014 20,945		20	2,095	2,095	2,793		10
11	Replace Door Operators On 3 Elevators	2014 36,600		20	1,830	1,830	2,135		11
12	Repaired Elevators	2015 7,578		20	379	379	379		12
13	Demolition Of Existing Walk-In Freezer/Cooler/Electrical	2015 7,240		20	362	362	362		13
14	Electrical Services For Walk-In Freezer/Cooler	2015 3,200		20	160	160	160		14
15	New Door Frame And New Glass Doors At Main Entrance	2015 11,580		20	579	579	579		15
16	New Walk-In Cooler/Freezer	2015 18,318		20	916	916	916		16
17	Wired Call System	2015 86,995		20	4,350	4,350	4,350		17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,498,508	\$ 17,384		\$ 251,951	\$ 234,567	\$ 4,485,529		34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 6,498,508	\$ 17,384		\$ 251,951	\$ 234,567	\$ 4,485,529
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 6,498,508	\$ 17,384		\$ 251,951	\$ 234,567	\$ 4,485,529

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 6,498,508	\$ 17,384		\$ 251,951	\$ 234,567	\$ 4,485,529
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 6,498,508	\$ 17,384		\$ 251,951	\$ 234,567	\$ 4,485,529

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,498,508	\$ 17,384		\$ 251,951	\$ 234,567	\$ 4,485,529	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		\$ 6,498,508	\$ 17,384		\$ 251,951	\$ 234,567	\$ 4,485,529	34

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	11,647		20	582	582	9,324	9
10	Various	2005	61,061		20	3,053	3,053	36,316	10
11	Universal Wide Style Handrail	2007	3,458		20	173	173	1,557	11
12	Furnish Hardware - Audio And Video Cable	2007	2,500		20	125	125	1,125	12
13	Duro Last Roofing System	2007	17,750		20	888	888	7,990	13
14	Fire Alram (Repair)	2007	4,364		20	218	218	1,964	14
15	Waterflow Labor/Pipe Fitting Fire Alram	2007	3,940		20	197	197	1,773	15
16	Walkway	2007	5,500		20	275	275	2,475	16
17	Renovated Parking Lot	2007	6,800		20	340	340	3,060	17
18	Fire Alarm Control Panel	2007	9,252		20	463	463	4,165	18
19	Duro Lasting Roof Work	2007	17,750		20	888	888	7,990	19
20	Bristol/Modules For Chiller	2007	5,832		20	292	292	2,626	20
21	Compresor Replacer	2007	2,823		20	141	141	1,269	21
22	Telephone System	2008	21,774		20	2,177	2,177	17,418	22
23	Digital Video Multiplexer Recorder, Color Dome Camera	2008	2,693		20	135	135	1,078	23
24	Elevator Car Doors	2008	3,875		20	194	194	1,551	24
25	Furnish and Install Insulated Glass Window	2008	25,820		20	1,291	1,291	10,328	25
26	Furnish and Install Solid Iron Fence	2008	4,860		20	243	243	1,944	26
27	Upholster Cornice & Roller Shades and Re-install	2008	27,819		20	1,391	1,391	11,128	27
28	Vinyl Floor Tile and Cove Base	2008	9,800		20	490	490	3,920	28
29	Tile work, Wallcoverings	2008	47,481		20	2,374	2,374	18,992	29
30	Renovation - Wallcoverings / Flooring / 1st & 2nd Floor	2008	29,588		20	1,479	1,479	11,834	30
31	Replacing Exit Faces and Lightbox Lexan Faces	2008	9,670		20	484	484	3,870	31
32	Capital Report Reconciliation	2008	(300)		20	(15)	(15)	(120)	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 335,757	\$		\$ 17,877	\$ 17,877	\$ 163,576	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 335,757	\$		\$ 17,877	\$ 17,877	\$ 163,576		1
2	K-020 IDPH Corrections-Demo & Carpentry, Painting,HVAC,								2
3	Plumbing - All Resident Rooms and Doctor Office Next Door	2012	85,025		20	4,251	4,251	17,005	3
4	Remove and Install Data Cables	2013	6,500		20	413	413	1,240	4
5	Remove and Installed Nre Fire Alarm Control Panel	2013	37,210		20	1,861	1,861	5,582	5
6	RECEPTACLES FOR KIOSKS	2013	4,055		20	203	203	609	6
7	SPRINKLER HEAD INSTALLATION	2013	2,850		20	143	143	428	7
8	Removed and Installed Cedar Fence on East & South Side of Building	2013	23,055		20	1,153	1,153	3,459	8
9	FIRE ALARM SYSTEM	2013	7,416		20	371	371	1,113	9
10	Install 15 Openings Power Outlets In 2Nd Flr Rooms For Wall Mount	2014	2,550		20	128	128	256	10
11	Replace 4 Doors With 20-Minute Fire Doors, Custom Match And Stair	2014	2,700		20	135	135	270	11
12	Construct Outside Patio Roof, Detach Structure From Building, Build	2014	2,545		20	127	127	254	12
13	Install Alarm Bell On South Passenger Elevator; Code Data Plates, An	2014	7,176		20	359	359	718	13
14	Caulking Windows	2014	22,500		20	1,125	1,125	2,250	14
15	Labor & Materials To Resurface 250 Doors, Remove Doors From Hin	2014	22,500		20	1,125	1,125	2,250	15
16	Roof Installation	2014	49,000		20	2,450	2,450	4,900	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)		\$ 610,839	\$		\$ 31,719	\$ 31,719	\$ 203,908	34

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from NuCare 7257 N. Lincoln Ave	2004	66,558	1,422	35	1,585	163	23,057	3
4	Allocated from Maestro 7257 N. Lincoln Ave	2004	11,152	286	35	319	33	3,863	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from NuCare Services	2003	808	47	20	28	(19)	483	9
10	Allocated from NuCare Services	2004	16,405	953	20	546	(407)	9,624	10
11	Allocated from NuCare Services	2005	973	57	20	34	(23)	520	11
12	Allocated from NuCare Services	2006	1,319	77	20	46	(31)	607	12
13	Allocated from NuCare Services	2008	1,390	81	20	48	(33)	493	13
14	Allocated from NuCare Services	2009	22,381	1,301	20	777	(524)	7,210	14
15	Allocated from NuCare Services	2010	3,439	200	20	143	(57)	775	15
16	Allocated from NuCare Services	2011	186	11	20	6	(5)	444	16
17	Allocated from NuCare Services	2012	207	12	20	7	(5)	37	17
18	Allocated from NuCare Services	2014	2,587	150	20	90	(60)	186	18
19	Allocated from NuCare Services	2015	728		20	5	5	6	19
20									20
21	Allocated from NuCare 7257 N. Lincoln Ave	2015	1,049	44	20	19	(25)	23	21
22	Allocated from NuCare 7257 N. Lincoln Ave	2005	6,067	36	20	320	284	4,014	22
23	Allocated from NuCare 7257 N. Lincoln Ave	2004	1,323		20	55	55	761	23
24									24
25									25
26	Allocated from Maestro 7257 N. Lincoln Ave	2015	176	9	20	4	(5)	4	26
27	Allocated from Maestro 7257 N. Lincoln Ave	2005	1,017	7	20	64	57	673	27
28	Allocated from Maestro 7257 N. Lincoln Ave	2004	222		20	11	11	127	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 137,987	\$ 4,693		\$ 4,107	\$ (586)	\$ 52,907	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 137,987	\$ 4,693		\$ 4,107	\$ (586)	\$ 52,907	1
2									2
3	Leasehold Improvements:								3
4	Allocated from Maestro Consulting Services	2003	544	5	20	4	(1)	325	4
5	Allocated from Maestro Consulting Services	2004	11,048	107	20	74	(33)	6,481	5
6	Allocated from Maestro Consulting Services	2005	655	6	20	5	(1)	350	6
7	Allocated from Maestro Consulting Services	2006	888	9	20	6	(3)	408	7
8	Allocated from Maestro Consulting Services	2008	936	9	20	6	(3)	332	8
9	Allocated from Maestro Consulting Services	2009	15,071	146	20	105	(41)	4,855	9
10	Allocated from Maestro Consulting Services	2010	2,316	22	20	19	(3)	522	10
11	Allocated from Maestro Consulting Services	2011	125	1	20	1		30	11
12	Allocated from Maestro Consulting Services	2012	139	1	20	1		25	12
13	Allocated from Maestro Consulting Services	2014	1,742	17	20	12	(5)	125	13
14	Allocated from Maestro Consulting Services	2015	490		20	1	1	4	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)		\$ 171,941	\$ 5,016		\$ 4,341	\$ (675)	\$ 66,364	34

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 764,502	\$ 5,164	\$ 49,456	\$ 44,292	10	\$ 503,537	71
72	Current Year Purchases	23,700	715	1,391	676	10	2,062	72
73	Fully Depreciated Assets	1,468,939		93	93	10	1,468,939	73
74								74
75	TOTALS	\$ 2,257,141	\$ 5,879	\$ 50,940	\$ 45,061		\$ 1,974,538	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1992 FORD VAN	1990	\$ 2,282	\$	\$	\$	5	\$	76
77		Allocated from NuCare Services (2015	611	36	59	23	5	611	77
78		Allocated from Maestro Consultin	2015	412	4	8	4	5	412	78
79										79
80	TOTALS			\$ 3,305	\$ 40	\$ 67	\$ 27		\$ 1,023	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,839,208	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,303	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 302,958	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 279,655	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,461,090	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2000 - 2002 Non-Care Assets	\$ 20,903	\$ 1,184	\$ 18,020	86
87	Clinic Project- new cabinetry, counter top	4,400	220	1,320	87
88	Dr. Stalling's Office - Front reception new	3,700	185	925	88
89	Xray Rm: demolish 4 door opening. furni	16,700	835	4,175	89
90	Dr. Rms-Floor,Wall,Countertop,Sink,Wir	8,500	425	1,700	90
91	TOTALS	\$ 54,203	\$ 2,849	\$ 26,140	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Jackson Square Nrsng. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Main Street (sale/leaseback arrangement)

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:	234		\$ 400,634			3
4	Additions			(400,634)			4
5	Allocated from NuCare Services Corp			2,633			5
6							6
7	TOTAL	234		\$ 2,633			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: \$ 34,101 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from NuCare Services Corp		\$	\$ 6,541	17
18	Allocated from Maestro Consulting Services			645	18
19					19
20					20
21	TOTAL		\$	\$ 7,186	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. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)								
			Units of Service	Cost	Units	Cost											
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	637,375	\$			\$	637,375				1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				223,030									223,030	2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39 - 03	hrs				694,310									694,310	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 prescripts							362,214						362,214	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>						160,150			120,922						281,072	13
14	TOTAL			\$			\$	1,714,865	\$	483,136			\$		2,198,001	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.

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning: 01/01/15

Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	\$ 2,080	\$ 24,693	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,613,276	2,613,276	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,800	3,800	6
7	Other Prepaid Expenses	23,717	23,717	7
8	Accounts Receivable (owners or related parties)		1,073,687	8
9	Other(specify):	160,866	160,866	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,803,739	\$ 3,900,039	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,794	3,794	16
17	Accumulated Depreciation (book methods)	(86)	(86)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	13,700	13,700	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(228)	(228)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,180	\$ 17,180	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,820,919	\$ 3,917,219	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 942,367	\$ 1,504,139	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	981,134	981,134	29
30	Accrued Salaries Payable	126,192	126,192	30
31	Accrued Taxes Payable (excluding real estate taxes)	411,840	411,840	31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,000	66,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	107,908	107,908	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,635,441	\$ 3,197,213	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,635,441	\$ 3,197,213	46
47	TOTAL EQUITY(page 18, line 24)	\$ 185,478	\$ 720,006	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,820,919	\$ 3,917,219	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3	Adjustment due to change in ownership	(1,350,670)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,350,670)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,536,148	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)	\$ 1,536,148	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)	\$ 185,478	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning: 01/01/15

Ending:

12/31/15

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 16,747,536	1
2	Discounts and Allowances for all Levels	(360,440)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,387,096	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,133,828	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,133,828	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	54,666	16
17	Sale of Drugs	7,635	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	90	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,721	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 65,112	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,061	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,061	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	79,498	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 79,498	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,670,595	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,163,413	31
32	Health Care	5,377,829	32
33	General Administration	4,004,738	33
B. Capital Expense			
34	Ownership	1,722,957	34
C. Ancillary Expense			
35	Special Cost Centers	2,219,994	35
36	Provider Participation Fee	645,516	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,134,447	40
41	Income before Income Taxes (line 30 minus line 40)**	1,536,148	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,536,148	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,207,954	44
45	Private Pay - Net Inpatient Revenue	974,868	45
46	Medicare - Net Inpatient Revenue	3,518,754	46
47	Other-(specify) Managed Care	1,231,771	47
48	Other-(specify) Hospice/Veterans	453,749	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 16,387,096	49

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

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

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

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

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	1,611	1,747	\$ 104,517	\$ 59.83	1
2	Assistant Director of Nursing	2,097	2,156	92,071	42.70	2
3	Registered Nurses	30,451	33,715	1,031,685	30.60	3
4	Licensed Practical Nurses	54,493	58,804	1,536,543	26.13	4
5	CNAs & Orderlies	107,722	118,968	1,391,926	11.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,607	3,980	62,846	15.79	8
9	Activity Director	1,739	2,087	39,683	19.01	9
10	Activity Assistants	8,680	9,700	105,825	10.91	10
11	Social Service Workers	7,054	7,417	181,117	24.42	11
12	Dietician					12
13	Food Service Supervisor	3,236	3,609	76,971	21.33	13
14	Head Cook	5,165	5,841	74,704	12.79	14
15	Cook Helpers/Assistants	17,837	19,909	210,044	10.55	15
16	Dishwashers					16
17	Maintenance Workers	3,589	3,935	70,797	17.99	17
18	Housekeepers					18
19	Laundry	2,604	2,604	27,342	10.50	19
20	Administrator	2,546	2,632	209,769	79.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,949	2,107	54,015	25.64	23
24	Clerical	10,915	11,894	220,868	18.57	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	745	839	37,771	45.02	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,086	3,287	47,354	14.41	33
34	TOTAL (lines 1 - 33)	269,126	295,231	\$ 5,575,848 *	\$ 18.89	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	\$ 24,496	01-03	35
36	Medical Director	Monthly 42,320	09-03	36
37	Medical Records Consultant			37
38	Nurse Consultant	132 7,530	10-03	38
39	Pharmacist Consultant	Monthly 29,473	10-03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	58,759	10a-03	42
43	Speech Therapy Consultant			43
44	Activity Consultant	37 1,980	11-03	44
45	Social Service Consultant			45
46	Other(specify) Psychiatric	Monthly 14,200	10-03	46
47	Nephrology	Monthly 3,000	10-03	47
48	Dental	Monthly 5,250	10-03	48
49	TOTAL (lines 35 - 48)	169 \$ 187,008		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rick Walworth	Administrator	0.00%	\$ 209,769	Workers' Compensation Insurance	\$ 211,378	IDPH License Fee	\$	
				Unemployment Compensation Insurance	137,762	Advertising: Employee Recruitment	580	
				FICA Taxes	418,119	Health Care Worker Background Check	5,546	
				Employee Health Insurance	351,921	(Indicate # of checks performed 554.6)		
				Employee Meals		Patient Background Checks	2,735	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	22,034	
				Pension Plan	23,271	License and Permits	6,233	
				Employee Physical	11,475	Allocated from NuCare Services Corp	9,231	
				Other Employee Benefits	13,535	Allocated from Maestro Consulting	3,115	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 209,769					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
NuCare Services Corp - Bookkeeping Fees	\$ 727,960						Out-of-State Travel	\$
Maestro Consulting Services - Bookkeeping Fees	227,703							
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
			\$ 955,663				Seminar Expense	8,596
							Allocated from NuCare Services Corp	1,298
							Allocated from Maestro Consulting	1,757
							Allocated from Integra HC Equipment	(346)
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)						\$	TOTAL	\$ 11,305
			\$ 179,169	TOTAL				

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Jackson Square Nrsg. & Rehab

0053686

Report Period Beginning:

01/01/15

Ending:

12/31/15

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. IL Council on Long Term Care \$30,140
- (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. \$ 337 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? Yes
If YES, give effective date of lease. 11/1/2015
- (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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Jackson Square Nursing and Rehab IDPH #0039834
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 645,516
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.