FOR BHF USE

LL1

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0051847

Facility Name: Burgess Square Hlthcare Ctr

Address: 5801 South Cass Ave (Number) Westmont (City) 60559 (Zip Code)

County: Dupage

Telephone Number: (630) 971-2645 **Fax #** (630)971-1961

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2012

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Andrew Cutler **Telephone Number:** (847) 940-3269
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Andrew B. Cutler, Managing Director
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
(Telephone) (847)374-0400 Fax # (847)964-5469

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,095	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	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,008	14,501	26,638	53,147	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,008	14,501	26,638	53,147	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.73%

D. How many bed-hold days during this year were paid by the Department?
24 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 203 and days of care provided 20,568

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	627,842	68,190	5,223	701,255		701,255		701,255			1
2	Food Purchase		368,315		368,315		368,315	(2,709)	365,606			2
3	Housekeeping	432,596	44,401		476,997		476,997		476,997			3
4	Laundry	30,032	2,098	141,116	173,246		173,246		173,246			4
5	Heat and Other Utilities			201,634	201,634		201,634		201,634			5
6	Maintenance	47,802	27,937	196,958	272,697		272,697	(9,674)	263,023			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,138,272	510,941	544,931	2,194,144		2,194,144	(12,383)	2,181,761			8
	B. Health Care and Programs											
9	Medical Director			83,210	83,210		83,210		83,210			9
10	Nursing and Medical Records	5,017,199	740,642	67,754	5,825,595		5,825,595		5,825,595			10
10a	Therapy	63,430	9,352		72,782		72,782		72,782			10a
11	Activities	233,124	20,281	1,173	254,578		254,578		254,578			11
12	Social Services	134,095			134,095		134,095		134,095			12
13	CNA Training											13
14	Program Transportation			10,974	10,974		10,974		10,974			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,447,848	770,275	163,111	6,381,234		6,381,234		6,381,234			16
	C. General Administration											
17	Administrative	165,633		709,431	875,064		875,064	(497,493)	377,571			17
18	Directors Fees											18
19	Professional Services			260,933	260,933		260,933	(1,115)	259,818			19
20	Dues, Fees, Subscriptions & Promotions			110,450	110,450		110,450	(63,545)	46,905			20
21	Clerical & General Office Expenses	528,486	96,536	536,510	1,161,532		1,161,532	(488,772)	672,760			21
22	Employee Benefits & Payroll Taxes			2,079,649	2,079,649		2,079,649		2,079,649			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,395	17,395		17,395		17,395			24
25	Other Admin. Staff Transportation			6,863	6,863		6,863		6,863			25
26	Insurance-Prop.Liab.Malpractice			103,482	103,482		103,482		103,482			26
27	Other (specify):*											27
28	**TOTAL General Administration**	694,119	96,536	3,824,713	4,615,368		4,615,368	(1,050,925)	3,564,443			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,280,239	1,377,752	4,532,755	13,190,746		13,190,746	(1,063,308)	12,127,438			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 Burgess Square Hlthcare Ctr #0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			105,459	105,459		105,459	(14,797)	90,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,106	40,106		40,106	(11,401)	28,705			32
33	Real Estate Taxes			147,939	147,939		147,939		147,939			33
34	Rent-Facility & Grounds			1,208,466	1,208,466		1,208,466		1,208,466			34
35	Rent-Equipment & Vehicles			48,181	48,181		48,181		48,181			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,550,151	1,550,151		1,550,151	(26,198)	1,523,953			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,924,651	1,389,116	52,502	3,366,269		3,366,269		3,366,269			39
40	Barber and Beauty Shops			33,502	33,502		33,502		33,502			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			308,762	308,762		308,762		308,762			42
43	Other (specify):*	151,138			151,138		151,138	(151,138)				43
44	**TOTAL Special Cost Centers**	2,075,789	1,389,116	394,766	3,859,671		3,859,671	(151,138)	3,708,533			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,356,028	2,766,868	6,477,672	18,600,568		18,600,568	(1,240,644)	17,359,924			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 Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,709)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,674)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,797)	30		9
10	Interest and Other Investment Income	(11,401)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions	(8,188)	20		20
21	Owner or Key-Man Insurance	(945)	17		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(229,134)	21		24
25	Fund Raising, Advertising and Promotional	(55,357)	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	(411,891)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (744,096)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(496,548)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (496,548)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,240,644)		37

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

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

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

Burgess Square Hlthcare Ctr

ID# 0051847

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (6,064)	21	1
2	Theft and Damage Loss	(10,922)	21	2
3	Finance Charges	(2,577)	21	3
4	Public Relations	(74,117)	21	4
5	Non- Allowable Marketing	(165,958)	21	5
6	Marketing Salaries	(151,138)	43	6
7	Non-Allowable Legal	(1,115)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
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**	(411,891)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burgess Square Hlthcare Ctr **#** 0051847 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,709)	0	0	0	0	0	0	0	0	0	0	(2,709)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(9,674)	0	0	0	0	0	0	0	0	0	0	(9,674)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,383)	0	0	0	0	0	0	0	0	0	0	(12,383)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(945)	(496,548)	0	0	0	0	0	0	0	0	0	(497,493)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,115)	0	0	0	0	0	0	0	0	0	0	(1,115)	19
20	Fees, Subscriptions & Promotions	(63,545)	0	0	0	0	0	0	0	0	0	0	(63,545)	20
21	Clerical & General Office Expenses	(488,772)	0	0	0	0	0	0	0	0	0	0	(488,772)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(554,377)	(496,548)	0	0	0	0	0	0	0	0	0	(1,050,925)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(566,760)	(496,548)	0	0	0	0	0	0	0	0	0	(1,063,308)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(14,797)	0	0	0	0	0	0	0	0	0	0	(14,797)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,401)	0	0	0	0	0	0	0	0	0	0	(11,401)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(26,198)	0	0	0	0	0	0	0	0	0	0	(26,198)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(151,138)	0	0	0	0	0	0	0	0	0	0	(151,138)	43
44	**TOTAL Special Cost Centers**	(151,138)	0	0	0	0	0	0	0	0	0	0	(151,138)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(744,096)	(496,548)	0	0	0	0	0	0	0	0	0	(1,240,644)	45

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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
John F. Vrba	44%			JAM Health Partners, LLC		Management Co.
Anthony Schreiber	30%					
Michael Hensley	26%					

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee	$ 496,548	JAM Health Partners, LLC	100.00%	$	$ (496,548)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 496,548			$	$ * (496,548)	14

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John F. Vrba	Partner	Administrative	44.00	0	60	100.00	Draw	$ 0		1
2	Anthony Schreiber	Partner	Administrative	30.00	0	60	100.00	Draw	201,938	17-3	2
3	Michael Hensley	Partner	Marketing	26.00	0	60	100.00	Draw	165,958	21-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 367,896		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 Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 2/31/2014

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 [X]

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

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

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Wintrust Bank		X	Working Capital	Various	5/1/13		1,120,000		Variable	40,106	6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,120,000			$ 40,106	9
	B. Non-Facility Related*											
10	Interst Income		X								(11,401)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,401)	14
15	TOTALS (line 9+line14)						$	$ 1,120,000			$ 28,705	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** N/A

*** 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 Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 147,939	2
3. Under or (over) accrual (line 2 minus line 1).		$ 147,939	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.)**		$	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 $ For 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.		$ 147,939	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011	137,002	10
2012	144,132	11
2013	147,939	12

Real Estate Taxes are not accrued as they are included in rent.
Rent expense is fixed therfore no accrual is required.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burgess Square Hlthcare Ctr COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0051847

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 940-3269 FAX #: (847) 964-5469

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-107-044	Nursing Home	$ 147,938.86	$ 147,938.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 147,938.86	$ 147,938.86

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Kitchen Exhaust Fan			2013	5,155		20	258	258	408	10
11	Door Exit System			2013	9,988		20	499	499	709	11
12	Patient Room Renovations (Flooring, Walls)			2013	36,005		20	1,800	1,800	2,250	12
13	Generator/Electric			2013	198,097		20	9,905	9,905	12,381	13
14	Electric - For Generator			2013	25,518		20	1,276	1,276	1,595	14
15	Flooring - (Lobby, Patient Rooms)			2013	70,424		20	3,521	3,521	4,108	15
16	Shower Room			2014	6,235		20	286	286	286	16
17	Flooring - (Lobby, Patient Rooms)			2014	4,950		20	124	124	124	17
18	Secure Door - Wander Guards			2014	7,048		20	147	147	147	18
19	Kitchen Floor			2014	29,268		20	488	488	488	19
20	HGR Soffit Replacement			2014	4,974		20	62	62	62	20
21	RAGO Electric - Downspout Heaters			2014	15,600		20	130	130	130	21
22	RAGO Electric 2 Additional Downspouts and Heaters			2014	1,400		20	11	11	11	22
23	Tile/Vinyl Replacement Rm 2214			2014	2,145		20	4	4	4	23
24	Tile/Vinyl Replacement Rm 2315			2014	2,445		20	79	79	79	24
25	Fire Door 500 Hallway			2014	1,075		20	9	9	9	25
26	Remodel 2500 Wing Rooms - Walls, Floors, Lighting			2014	18,900		20	10	10	10	26
27	Overbed Lights/Wall Switches			2014	4,677		20				27
28	Commercial Hot Water Heater - Dave Soltwisch Plumbing			2014	7,459		20				28
29	Carpet/Tile Rm 2216			2014	4,950		20	124	124	124	29
30	Replace 31' 4" Cast Iron Piping - Kitchen			2014	16,700		20	348	348	348	30
31	Elevator Car Door Restrictors			2014	3,500		20	87	87	87	31
32	Convert 2500 Ofc/Nurses Station (Paint/Wallpaper Rms 2310,2315,2214)			2014	4,280		20	53	53	53	32
33	Parking Lot			2014	623,718		20	5,198	5,198	5,198	33
34	Light Posts			2014	25,869		20	216	216	216	34
35	Lawn Sprinkler System			2014	21,900		20	183	183	183	35
36	Book Depreciation					105,459					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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,152,280	$ 105,459		$ 24,818	$ 24,818	$ 29,010	70

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	$ 265,517	$	$ 65,844	$ 65,844		$ 127,997	71
72	Current Year Purchases	122,534						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 388,051	$	$ 65,844	$ 65,844		$ 127,997	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 1,540,331	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 105,459	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 90,662	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (14,797)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 157,007	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Door Project	$ 5,721	92
93			93
94			94
95		$ 5,721	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 Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: The Ream Group
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. [X] 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:		203		$ 1,204,709			3
4	Additions							4
5	Storage Pods				3,757			5
6								6
7	TOTAL		203		$ 1,208,466 **			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: [X] YES [ ] NO Terms: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 48,181 Description: See Attached
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

Description	Amount
Cable/Telephone Equipment	17980
Chillers	15384
Water Softner	3026
Postage Meter	1020
Ice Machine	2160
Business Internet Router	2614
Printers & Copiers	5997
	48,181

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-1	hrs	$ 784,381		$	$		$ 784,381	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	43,290					43,290	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	1,096,980					1,096,980	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				1,200,868		1,200,868	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					52,502	188,248		240,750	13
14	TOTAL			$ 1,924,651		$ 52,502	$ 1,389,116		$ 3,366,269	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.

	Special Services - Supplies (Column 6 - Other)	Amount
13	Radiology Medicare- Cost	74,208
13	Laboratory - Medicare -Cost	32,696
13	Other Outside Service - Medicare - Cost	81,344
		188,248

	Special Services - Services (Column 5 - Other)	
13	Respiratory Therapy	52,502
		52,502

Facility Name & ID Number Burgess Square Hlthcare Ctr **#** 0051847 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2014 **(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	$ 908,634	$	1
2	Cash-Patient Deposits	17,418		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,552,248		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	191,846		6
7	Other Prepaid Expenses	11,329		7
8	Accounts Receivable (owners or related parties)	100		8
9	Other(specify): See Attached	318,115		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,999,690	$	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	1,117,694		15
16	Equipment, at Historical Cost	388,591		16
17	Accumulated Depreciation (book methods)	(144,958)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			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)**	$ 1,361,327	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,361,017	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 818,340	$	26
27	Officer's Accounts Payable	168,135		27
28	Accounts Payable-Patient Deposits	17,418		28
29	Short-Term Notes Payable	1,120,000		29
30	Accrued Salaries Payable	437,034		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,481		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	646,077		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,237,485	$	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)**	$ 3,237,485	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,123,532	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,361,017	$	48

***(See instructions.)**

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	Other Current Assets:	Amount	Amount
9	Due from 401(k) Plan	6500	
9	Option Deposit	300,000	
9	State Tax Overpayment Credit	4,209	
9	Utility Deposits	200	
9	Employee Loan, Advances, Wage Assignments	1,485	
9	New Door Project	5,721	
	Total Line 9	318,115	0

	Other Non-Current Assets:	Amount	Amount
23			
23			
23			
23			
23			
23			
23			
	Total Line 23	0	0

	Other Current Liabilities:	Amount	Amount
36	Accrued Vacation	67,500	
36	Accrued 401K Match	12,080	
36	Private Pay Holding Account	173,883	
36	BCBS Liability	15,409	
36	Accrued Occupancy Tax	80,979	
36	Due To Jam	295,000	
36	Accrued Rent	1,227	
36	Accrued Bed Tax	-1	
	Total Line 36	646,077	0

	Other Non-Current Liabilities:	Amount	Amount
43			
43			

43			
43			
43			
43			
43			
43			
	Total Line 43	0	0

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,402,401	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,402,401	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	721,131	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)**	$ 721,131	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)**	$ 2,123,532	24 *

*** This must agree with page 17, line 47.**

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,917,895	1
2	Discounts and Allowances for all Levels	(8,981,732)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,936,163	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,139,637	6
7	Oxygen	49,637	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,189,274	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	2,079	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,832,515	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	174,748	19
20	Radiology and X-Ray	111,581	20
21	Other Medical Services	1,050,650	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,171,573	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,401	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,401	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Other Income**	1,363	28
28a	**Private Refund Policy**	11,925	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,288	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,321,699	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,194,144	31
32	Health Care	6,381,234	32
33	General Administration	4,615,368	33
	B. Capital Expense		
34	Ownership	1,550,151	34
	C. Ancillary Expense		
35	Special Cost Centers	3,550,909	35
36	Provider Participation Fee	308,762	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,600,568	40
41	**Income before Income Taxes (line 30 minus line 40)****	721,131	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 721,131	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,742,023	44
45	Private Pay - Net Inpatient Revenue	3,396,284	45
46	Medicare - Net Inpatient Revenue	2,735,523	46
47	Other-(specify) **Insurance**	1,948,118	47
48	Other-(specify) **Hospice**	114,215	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,936,163	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,345	4,191	$ 186,298	$ 44.45	1
2	Assistant Director of Nursing	1,984	2,080	74,567	35.85	2
3	Registered Nurses	60,727	66,499	2,055,654	30.91	3
4	Licensed Practical Nurses	27,659	30,212	873,000	28.90	4
5	CNAs & Orderlies	111,603	120,477	1,731,352	14.37	5
6	CNA Trainees					6
7	Licensed Therapist	43,567	46,787	1,924,651	41.14	7
8	Rehab/Therapy Aides	3,387	3,910	63,430	16.22	8
9	Activity Director	527	766	25,407	33.17	9
10	Activity Assistants	11,667	14,470	207,717	14.36	10
11	Social Service Workers	5,893	6,352	134,095	21.11	11
12	Dietician	1,832	2,080	59,177	28.45	12
13	Food Service Supervisor	3,899	4,171	82,296	19.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,897	33,025	486,369	14.73	15
16	Dishwashers					16
17	Maintenance Workers	1,893	2,157	47,802	22.16	17
18	Housekeepers	27,614	31,089	432,596	13.91	18
19	Laundry	2,123	2,273	30,032	13.21	19
20	Administrator	3,920	4,160	165,633	39.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,222	18,614	528,486	28.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,428	5,168	96,328	18.64	31
32	Other Health Care(specify)					32
33	Other(specify) Dir. Of Marketing	3,749	3,909	151,138	38.66	33
34	TOTAL (lines 1 - 33)	366,936	402,390	$ 9,356,028 *	$ 23.25	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,223	1-3	35
36	Medical Director	Montly	83,210	9-3	36
37	Medical Records Consultant	18	1,080	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,812	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,173	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultants	Monthly	38,250	10-3	47
48					48
49	TOTAL (lines 35 - 48)	41	$ 141,748		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		15,612	10-3	52
53	TOTAL (lines 50 - 52)		$ 15,612		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Neil Glein	Administrator	0	$ 165,633
Kristen Thrun	Administrtaor	0	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 165,633

B. Administrative - Other

Description	Amount
Administrative Management	$ 212,883
Management Fee - JAM Health Partners, LLC	496,548
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 709,431

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network, Inc.	Data Processing	$ 3,048
E Health Data Solutions	Data Processing	8,451
It's Never 2 Late	Data Processing	2,620
Optima Healthcare Solutions, Inc.	Data Processing	7,468
Telemedicine Solutions, LLC	Data Processing	8,100
Wescom Solutions, Inc.	Data Processing	31,831
GFS, Inc	Data Processing	675
Duane Morris	Legal	19,926
Meyers & Flowers	Legal	6,185
FGMK, LLC	Accounting/Consulting	80,025
ADP	Payroll Services	86,104
Pharmacy Price Mgt.	Other Professional	6,500
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 260,933

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,629
Health Care Worker Background Check (Indicate # of checks performed 133)	2,020
Patient Background Checks 982	9,820
Licenses & Fees	10,762
Dues & Subscriptions	19,730
Advertising & Promotion	55,357
Less: Public Relations Expense	( )
Non-allowable advertising	(55,357)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,961

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	17,395
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,395

* Attach copy of IMRF notifications

**See instructions.

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Invoice Date	Vendor	Amount
1/16/2014	Duane Morris, LLP	1,063
1/24/2014	Meyers & Flowers, LLC	6,440
2/11/2014	A/R Cash Receipt - A/R import - Legal Fees	(2,400)
3/1/2014	Duane Morris, LLP	270
4/17/2014	Meyers & Flowers, LLC	1,560
5/9/2014	Meyers & Flowers, LLC	195
7/15/2014	Duane Morris, LLP	170
8/14/2014	Duane Morris, LLP	4,980
9/15/2014	Duane Morris, LLP	5,861
10/13/2014	Duane Morris, LLP	2,363
11/10/2014	Duane Morris, LLP	4,733
11/11/2014	Meyers & Flowers, LLC	228
12/4/2014	Meyers & Flowers, LLC	163
12/4/2014	Duane Morris, LLP	487
	Total	26,111
	Page 5 Adjustment	(1,115)
	Total Legal	24,996

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

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

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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. **IHCA - $12,221**

(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 Year**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **73,334** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **308,762**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,079**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
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? **Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) 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.