FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 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) -71-1961

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 1/1/2015 to 12/31/2015 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: 1/1/2015 Ending: 12/31/2015

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	5,487	13,964	32,061	51,512	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,487	13,964	32,061	51,512	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.52%

D. How many bed-hold days during this year were paid by the Department?
0 (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 1/1/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2012 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 19,786

Medicare Intermediary Wisconsin Physicans 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: 1/1/2015 Ending: 12/31/2015

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	606,157	75,407	3,589	685,153		685,153		685,153			1
2	Food Purchase		371,040		371,040		371,040	(1,746)	369,294			2
3	Housekeeping	460,102	45,666		505,768		505,768		505,768			3
4	Laundry	29,604	3,941	134,894	168,439		168,439		168,439			4
5	Heat and Other Utilities			196,414	196,414		196,414		196,414			5
6	Maintenance	46,393	34,815	152,714	233,922		233,922	(18,658)	215,264			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,142,256	530,869	487,611	2,160,736		2,160,736	(20,404)	2,140,332			8
	B. Health Care and Programs											
9	Medical Director			89,907	89,907		89,907		89,907			9
10	Nursing and Medical Records	4,962,556	752,113	90,043	5,804,712		5,804,712		5,804,712			10
10a	Therapy	99,147	3,246		102,393		102,393		102,393			10a
11	Activities	180,827	13,105	1,403	195,335		195,335		195,335			11
12	Social Services	157,738			157,738		157,738		157,738			12
13	CNA Training											13
14	Program Transportation			23,441	23,441		23,441		23,441			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,400,268	768,464	204,794	6,373,526		6,373,526		6,373,526			16
	C. General Administration											
17	Administrative	113,651		937,995	1,051,646		1,051,646	(937,995)	113,651			17
18	Directors Fees											18
19	Professional Services			268,588	268,588		268,588	(11,940)	256,648			19
20	Dues, Fees, Subscriptions & Promotions			76,984	76,984		76,984	(35,083)	41,901			20
21	Clerical & General Office Expenses	624,749	68,377	848,002	1,541,128		1,541,128	(506,060)	1,035,068			21
22	Employee Benefits & Payroll Taxes			1,795,429	1,795,429		1,795,429		1,795,429			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,712	19,712		19,712	(3,182)	16,530			24
25	Other Admin. Staff Transportation			6,146	6,146		6,146	(1,696)	4,450			25
26	Insurance-Prop.Liab.Malpractice			107,451	107,451		107,451		107,451			26
27	Other (specify):*											27
28	**TOTAL General Administration**	738,400	68,377	4,060,307	4,867,084		4,867,084	(1,495,956)	3,371,128			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,280,924	1,367,710	4,752,712	13,401,346		13,401,346	(1,516,360)	11,884,986			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: 1/1/2015 Ending: 12/31/2015

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			165,256	165,256		165,256		165,256			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,824	46,824		46,824	(520)	46,304			32
33	Real Estate Taxes			152,543	152,543		152,543		152,543			33
34	Rent-Facility & Grounds			1,203,375	1,203,375		1,203,375		1,203,375			34
35	Rent-Equipment & Vehicles			32,944	32,944		32,944		32,944			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,600,942	1,600,942		1,600,942	(520)	1,600,422			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,975,960	1,436,016	51,265	3,463,241		3,463,241		3,463,241			39
40	Barber and Beauty Shops			31,175	31,175		31,175		31,175			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			306,608	306,608		306,608		306,608			42
43	Other (specify):*	181,436			181,436		181,436	(181,436)				43
44	**TOTAL Special Cost Centers**	2,157,396	1,436,016	389,048	3,982,460		3,982,460	(181,436)	3,801,024			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,438,320	2,803,726	6,742,702	18,984,748		18,984,748	(1,698,316)	17,286,432			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: 1/1/2015 Ending: 12/31/2015

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	(1,746)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,015)	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				9
10	Interest and Other Investment Income	(520)	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	(4,160)	20		20
21	Owner or Key-Man Insurance	(5,378)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(281,890)	21		24
25	Fund Raising, Advertising and Promotional	(30,923)	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	(423,689)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (760,321)		$	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)	(937,995)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (937,995)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,698,316)		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: 1/1/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (6,643)	6	1
2	Non-Allowable Legal	(11,940)	19	2
3	Non-Allowable Marketing/Public Relations	(216,918)	21	3
4	Finance Charges	(1,874)	21	4
5	Non-Allowable Seminar Expense	(3,182)	24	5
6	Marketing Salaries	(181,436)	43	6
7	Non-Allowable Travel - Marketing	(1,696)	25	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**	(423,689)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 **Report Period Beginning:** 1/1/2015 **Ending:** 12/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,746)	0	0	0	0	0	0	0	0	0	0	(1,746)	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	(18,658)	0	0	0	0	0	0	0	0	0	0	(18,658)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(20,404)	0	0	0	0	0	0	0	0	0	0	(20,404)	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 Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(937,995)	0	0	0	0	0	0	0	0	0	(937,995)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,940)	0	0	0	0	0	0	0	0	0	0	(11,940)	19
20	Fees, Subscriptions & Promotions	(35,083)	0	0	0	0	0	0	0	0	0	0	(35,083)	20
21	Clerical & General Office Expenses	(506,060)	0	0	0	0	0	0	0	0	0	0	(506,060)	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	(3,182)	0	0	0	0	0	0	0	0	0	0	(3,182)	24
25	Other Admin. Staff Transportation	(1,696)	0	0	0	0	0	0	0	0	0	0	(1,696)	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**	(557,961)	(937,995)	0	0	0	0	0	0	0	0	0	(1,495,956)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(578,365)	(937,995)	0	0	0	0	0	0	0	0	0	(1,516,360)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burgess Square Hlthcare Ctr **#** 0051847 **Report Period Beginning:** 1/1/2015 **Ending:** 12/31/2015

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(520)	0	0	0	0	0	0	0	0	0	0	(520)	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**	(520)	0	0	0	0	0	0	0	0	0	0	(520)	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):*	(181,436)	0	0	0	0	0	0	0	0	0	0	(181,436)	43
44	**TOTAL Special Cost Centers**	(181,436)	0	0	0	0	0	0	0	0	0	0	(181,436)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(760,321)	(937,995)	0	0	0	0	0	0	0	0	0	(1,698,316)	45

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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%			JAM Insurance Holdings, LLC		Holding Co.
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	$ 937,995	JAM Health Partners, LLC	100.00%	$	$ (937,995)	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			$ 937,995			$	$ * (937,995)	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: 1/1/2015 Ending: 12/31/2015

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: 1/1/2015 Ending: 12/31/2015

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	$ 56,286	21	1
2	Anthony Schreiber	Partner	Administrative	30.00	0	60	100.00	Draw	217,687	21	2
3	Michael Hensley	Partner	Marketing	26.00	0	60	100.00	Draw	178,756	21	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 452,729		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: 1/1/2015 Ending: 2/31/2015

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: 1/1/2015 Ending: 12/31/2015

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		875,000		Variable	46,824	6
7												7
8												8
9	TOTAL Facility Related						$	$ 875,000			$ 46,824	9
	B. Non-Facility Related*											
10	Interest Income		X								(520)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (520)	14
15	TOTALS (line 9+line14)						$	$ 875,000			$ 46,304	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: 1/1/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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.)		$ 152,543	2
3. Under or (over) accrual (line 2 minus line 1).		$ 152,543	3
4. Real Estate Tax accrual used for 2015 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.		$ 152,543	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011	137,002	9
2012	144,132	10
2013	147,939	11
2014	152,543	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 2014	$	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.

2014 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-107-044	Nursing Home	$ 152,543.00	$ 152,543.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 152,543.00	$ 152,543.00

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 1/1/2015 Ending: 12/31/2015

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: 1/1/2015 Ending: 12/31/2015

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	Kitchen Exhaust Fan			2013	5,155		20	258	258	666	9
10	Door Exit System			2013	9,988		20	499	499	1,208	10
11	Patient Room Renovations (Flooring, Walls)			2013	36,005		20	1,800	1,800	4,050	11
12	Generator/Electric			2013	198,097		20	9,905	9,905	22,286	12
13	Electric - For Generator			2013	25,518		20	1,276	1,276	2,871	13
14	Flooring - (Lobby, Patient Rooms)			2013	70,424		20	3,521	3,521	7,629	14
15	Shower Room			2014	6,235		20	312	312	598	15
16	Flooring - (Lobby, Patient Rooms)			2014	4,950		20	248	248	372	16
17	Secure Door - Wander Guards			2014	7,048		20	352	352	499	17
18	Kitchen Floor			2014	29,268		20	1,463	1,463	1,951	18
19	HGR Soffit Replacement			2014	4,974		20	249	249	311	19
20	RAGO Electric - Downspout Heaters			2014	15,600		20	780	780	910	20
21	RAGO Electric 2 Additional Downspouts and Heaters			2014	1,400		20	70	70	81	21
22	Tile/Vinyl Replacement Rm 2214			2014	2,145		20	107	107	116	22
23	Tile/Vinyl Replacement Rm 2315			2014	2,445		20	122	122	132	23
24	Fire Door 500 Hallway			2014	1,075		20	54	54	58	24
25	Remodel 2500 Wing Rooms - Walls, Floors, Lighting			2014	18,900		20	945	945	1,024	25
26	Overbed Lights/Wall Switches			2014	4,677		20	234	234	234	26
27	Commercial Hot Water Heater - Dave Soltwisch Plumbing			2014	7,459		20	373	373	373	27
28	Lawn Sprinkler System			2014	21,900		20	1,095	1,095	1,278	28
29	Replace 31' 4" Cast Iron Piping - Kitchen			2014	16,700		20	835	835	1,183	29
30	Elevator Car Door Restrictors			2014	3,500		20	175	175	262	30
31	Convert 2500 Ofc/Nurses Station (Paint/Wallpaper Rms 2310,										31
32	2315,2214) Soffit			2014	4,280		20	214	214	267	32
33	Parking Lot			2014	623,718		20	31,186	31,186	36,384	33
34	Light Posts			2014	25,869		20	1,293	1,293	1,509	34
35											35
36	Book Depreciation					165,256					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: 1/1/2015 Ending: 12/31/2015

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	Parking Lot Additions	2015	$ 5,775	$	20	$ 193	$ 193	$ 193	37
38	Energy Efficient Windows All Patient Rooms West Side of Facility	2015	45,647		20	571	571	571	38
39	New Door Project - 2500 Wing	2015	6,071		15	253	253	337	39
40	Flooring Rm 2204- Maple Vinyl planks and Vinyl Base	2015	2,923		20	49	49	49	40
41	Roof Repair by HVAC Unit Hole/Leak Repair	2015	3,720		20	31	31	31	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)		$ 1,211,466	$ 165,256		$ 58,463	$ 58,463	$ 87,433	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: 1/1/2015 Ending: 12/31/2015

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	$ 388,051	$	$ 74,807	$ 74,807		$ 202,804	71
72	Current Year Purchases	103,278		6,664	6,664		6,664	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 491,329	$	$ 81,471	$ 81,471		$ 209,468	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)	$ 1,702,795	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 165,256	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 139,934	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (25,322)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 296,901	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	New Roof Improvements	$ 53,313	92
93	Parking Lot Code Updates	2,602	93
94			94
95		$ 55,915	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: 1/1/2015 Ending: 12/31/2015

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		$ 1,200,787			3
4	Additions							4
5								5
6	Storage Pods				2,588			6
7	TOTAL		203		$ 1,203,375 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 32,944 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
Telephone Equipment	7,669
Chillers	15,384
Water Softner	2,280
Postage Meter	1,020
Ice Machine	2,160
Business Internet Router	2,933
Printers & Copiers	1,498
	32,944

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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: 1/1/2015 Ending: 12/31/2015

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-1	hrs	$ 793,052		$	$		$ 793,052	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	57,540					57,540	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	1,125,368					1,125,368	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				1,239,162		1,239,162	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					51,265	196,854		248,119	13
14	TOTAL			$ 1,975,960		$ 51,265	$ 1,436,016		$ 3,463,241	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	74,014
13	Laboratory - Medicare -Cost	41,308
13	Other Outside Service - Medicare - Cost	81,532
		196,854

	Special Services - Services (Column 5 - Other)	
13	Respiratory Therapy	51,265
		51,265

STATE OF ILLINOIS

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 421,150	$	1
2	Cash-Patient Deposits	11,085		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,344,868		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	203,344		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	100		8
9	Other(specify): See Attached	322,396		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,302,943	$	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	1,175,187		15
16	Equipment, at Historical Cost	491,869		16
17	Accumulated Depreciation (book methods)	(310,214)		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): See Attached	55,915		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,412,757	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,715,700	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 320,201	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,085		28
29	Short-Term Notes Payable	875,000		29
30	Accrued Salaries Payable	84,896		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,624		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	758,999		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,058,805	$	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)**	$ 2,058,805	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,656,895	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,715,700	$	48

***(See instructions.)**

Burgess Square Healthcare and Rehabilitation Centre, LLC
0051847
Page 17 Supplemental
1/1/15-12/31/15

	Other Current Assets:	Amount	Amount
9	Due from Prior Owner	17987	
9	Option Deposit	300,000	
9	State Tax Overpayment Credit	4,209	
9	Utility Deposits	200	
9			
9			
	Total Line 9	322,396	0

	Other Non-Current Assets:	Amount	Amount
23	CIP - New Roof Improvements	53,313	
23	CIP- Parking Lot Code Updates	2,602	
23			
23			
23			
23			
23			
	Total Line 23	55,915	0

	Other Current Liabilities:	Amount	Amount
36	Accrued Vacation	67,500	
36	Accrued 401K Match	14,600	
36	Private Pay Holding Account	212,415	
36	BCBS Liability	80,408	
36	Accrued Occupancy Tax	88,099	
36	Due To Jam	294,750	
36	Accrued Rent	1,227	
36			
	Total Line 36	758,999	0

	Other Non-Current Liabilities:	Amount	Amount
43			
43			

43			
43			
43			
43			
43			
43			
	Total Line 43	0	0

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,123,532	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,123,532	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	533,363	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)**	$ 533,363	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)**	$ 2,656,895	24	*

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	$ 19,050,784	1
2	Discounts and Allowances for all Levels	(9,378,012)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,672,772	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,352,509	6
7	Oxygen	57,881	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,410,390	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	1,746	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	1,881,951	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	395,898	19
20	Radiology and X-Ray	104,706	20
21	Other Medical Services	1,024,090	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,408,391	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	520	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 520	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Private Refund Policy Income	26,038	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,038	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,518,111	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,160,736	31
32	Health Care	6,373,526	32
33	General Administration	4,867,084	33
	B. Capital Expense		
34	Ownership	1,600,942	34
	C. Ancillary Expense		
35	Special Cost Centers	3,675,852	35
36	Provider Participation Fee	306,608	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,984,748	40
41	**Income before Income Taxes (line 30 minus line 40)****	533,363	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 533,363	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 695,751	44
45	Private Pay - Net Inpatient Revenue	3,339,671	45
46	Medicare - Net Inpatient Revenue	2,276,146	46
47	Other-(specify) Insurance	3,244,616	47
48	Other-(specify) Hospice	116,588	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,672,772	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.**

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	3,298	3,793	$ 162,085	$ 42.73	1
2	Assistant Director of Nursing	1,960	2,080	84,335	40.55	2
3	Registered Nurses	53,965	61,447	1,935,431	31.50	3
4	Licensed Practical Nurses	28,724	32,948	968,235	29.39	4
5	CNAs & Orderlies	100,703	117,874	1,736,735	14.73	5
6	CNA Trainees					6
7	Licensed Therapist	45,731	50,964	1,975,960	38.77	7
8	Rehab/Therapy Aides	4,021	4,534	99,147	21.87	8
9	Activity Director	562	781	23,122	29.61	9
10	Activity Assistants	9,837	10,874	157,705	14.50	10
11	Social Service Workers	5,012	5,412	157,738	29.15	11
12	Dietician	1,856	2,080	60,797	29.23	12
13	Food Service Supervisor	2,060	2,322	47,603	20.50	13
14	Head Cook	30,173				14
15	Cook Helpers/Assistants		33,676	497,757	14.78	15
16	Dishwashers	1,880				16
17	Maintenance Workers	27,773	2,112	46,393	21.97	17
18	Housekeepers	1,798	31,661	460,102	14.53	18
19	Laundry	2,936	2,075	29,604	14.27	19
20	Administrator		3,200	113,651	35.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,077	21,254	624,749	29.39	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	3,586	4,142	75,735	18.28	31
32	Other Health Care(specify)					32
33	Other(specify) Director of Marke	3,560	3,920	181,436	46.28	33
34	TOTAL (lines 1 - 33)	348,512	397,149	$ 9,438,320 *	$ 23.77	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	56	$ 3,589	01-03	35
36	Medical Director	Monthly	89,907	09-03	36
37	Medical Records Consultant	13	795	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,624	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,403	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultants	Monthly	78,624	10-03	47
48					48
49	TOTAL (lines 35 - 48)	97	$ 184,942		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				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Neil Glein	Administrator	0	$ 113,651
Kristen Thrun	Administrator	0	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 113,651

B. Administrative - Other

Description	Amount
Management Fee - JAM Health Partners, LLC	$ 937,995
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 937,995

C. Professional Services

Vendor/Payee	Type	Amount
Ability/E-Health Data/GFS	Data Processing	$ 12,745
It's Never 2 Late	Data Processing	2,550
Optima Healthcare Solutions	Data Processing	5,163
Stratus Video Interpreting	Data Processing	1,051
Telemedicine Solutions	Data Processing	8,100
Wescom Solutions	Data Processing	51,609
FGMK	Accounting/Consulting	75,594
Duane Morris	Legal	20,945
Meyers & Flowers/Clausen Miller	Legal	1,391
Grotefeld & Hoffman	Legal	14,474
2401 Corporate	Other Professional	1,140
ADP	Payroll Processing	73,826
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 268,588

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 205,983
Unemployment Compensation Insurance	
FICA Taxes	827,696
Employee Health Insurance	625,821
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
HSA	11,678
401(k) Match	15,400
Other Employee Benefits	108,851
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,795,429

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	7,650
Health Care Worker Background Check	600
(Indicate # of checks performed 60)	
Patient Background Checks 540	5,400
Dues & Subscriptions	12,592
Licenses & Fees	5,755
Advertising & Promotion	30,923
Less: Public Relations Expense	( )
Non-allowable advertising	(30,923)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,977

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	16,530
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,530

**See instructions.

Burgess Square
0051847
Legal Schedule
01/01/2015-12/31/2015

Date	Vendor	Description	Debit	Credit	Non-Allowable	Total
1/31/2015	Duane Morris, LLP	Non Retainer Legal Services	1,898		1,898	-
1/31/2015	Duane Morris, LLP	Non Retainer Legal Services	2,796			2,796
1/31/2015	CR01	Non Retainer Legal Services		5,000		(5,000)
2/28/2015	Duane Morris, LLP	Non Retainer Legal Services	146			146
5/31/2015	Grotefeld Hoffman Schleiter Gordon & Och	Non Retainer Legal Services	3,141		3,141	0
5/31/2015	Duane Morris, LLP	Non Retainer Legal Services	3,197		3,197	-
6/30/2015	Duane Morris, LLP	Retainer Fees	449		449	-
7/31/2015	Grotefeld Hoffman Schleiter Gordon & Och	Non Retainer Legal Services	1,673			1,673
7/31/2015	Grotefeld Hoffman Schleiter Gordon & Och	Non Retainer Legal Services	840			840
7/31/2015	Meyers & Flowers, LLC	Non Retainer Legal Services	300			300
7/31/2015	Clausen Miller, P.C.	Non Retainer Legal Services	656			656
8/31/2015	Duane Morris, LLP	Non Retainer Legal Services	3,685			3,685
8/31/2015	Hamlin & Burton Liability Management,Inc	Non Retainer Legal Services	2,590		2,590	(0)
9/30/2015	Duane Morris, LLP	Non Retainer Legal Services	1,284			1,284
9/30/2015	Duane Morris, LLP	Non Retainer Legal Services	5,231			5,231
9/30/2015	Meyers & Flowers, LLC	Non Retainer Legal Services	69			69
10/31/2015	Grotefeld Hoffman Schleiter Gordon & Och	Non Retainer Legal Services	4,290			4,290
10/31/2015	Grotefeld Hoffman Schleiter Gordon & Och	Non Retainer Legal Services	1,940			1,940
10/31/2015	Duane Morris, LLP	Retainer Fees	299		299	-
11/30/2015	Duane Morris, LLP	Non Retainer Legal Services	651			651
12/31/2015	Duane Morris, LLP	Non Retainer Legal Services	6,311			6,311
12/31/2015	Meyers & Flowers, LLC	Non Retainer Legal Services	366		366	(0)
			41,810	5,000	11,940	24,871

Burgess Square
0051847
Seminar Schedule
01/01/2015-12/31/2015

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	Non-Allowable	Allowable
1/31/2015	CE Solutions	fee for service	all staff	N/A	Webinar	3,360.00		3,360.00
1/31/2015	CE Solutions	fee for service	all staff	N/A	Webinar	1,305.00		1,305.00
2/28/2015	AMERICAN EXPRESS	Fall prevention	John Vrba	owner	Webinar	75.00		75.00
2/28/2015	Fred Pryor Careertrac	human resources	Neil Glein	Administrator	Oakbrook, IL	149.00		149.00
2/28/2015	Fred Pryor Careertrac	human resources	Anthony Schreiber	owner	Oakbrook, IL	298.00		298.00
3/31/2015	Illinois Health Care Association	unknown	John Vrba	owner	Springfield, IL	45.00		45.00
3/31/2015	Assoc. of Nutrition & Foodservice	Nutrition	Sam Allen	dietary supervisor	Rosemont, IL	149.00		149.00
3/31/2015	cash	Food Handling course	Maria Wells	dietary supervisor	Webinar	9.95		9.95
4/30/2015	Illinois Health Care Association	The 5th Stage of Grief	Kristin Thrun, Kathy Petersen	Adminstrator, Admissions	Springfield, IL	75.00		75.00
4/30/2015	Downers grove CPR	CPR	misc staff	nursing staff	Downers Grove	300.00		300.00
4/30/2015	Illinois Academy of Nutrition	Nutrition	Jennifer Meyers	dietitian	Henry, IL	115.00		115.00
4/30/2015	LSVT Global	LSVT Big Training and Certification Workshop	john lyndon lao	therapy director	Chicago, IL	580.00		580.00
4/30/2015	Illinois Health Care Association	The 5th Stage of Grief	Peggy An Runowski, Anna Millitello, Kathy Jo Peterson	MDS, DON, Admissions	Webinar	60.00		60.00
5/7/2015	Downers grove CPR	CPR	staff	miscellaneous nursing staff	Downers Grove	210.00		210.00
5/31/2015	Cross Country Education	Practical Applications of Manual Lymphatic Therapy	Phillip Garcia	Physical Therapist	Downers Grove	199.00		199.00
4/29/2015	Downers grove CPR	CPR	staff	miscellaneous nursing staff	Downers Grove	210.00		210.00
6/30/2015	Cash Receipts	refund of activity director course	Karin Knutson	Activities Director	des plaines	(440.00)		(440.00)
6/30/2015	Illinois Health Care Association	Count down to ICD-10 Making Sure your coders are ready	Peg Runowski, Kelly Ciger, KJ Petersen, Anna Militello, Lynn Patti, Lyndon Lao	MDS, Don, Admissions, RN, Bo	Lisle, IL	750.00		750.00
6/30/2015	Illinois Health Care Association	I Want My Stars Back	John Vrba, KJ Petersen	owner, admissions	Lisle, IL	290.00		290.00
6/30/2015	Illinois Health Care Association	OASIS Training: Safely Reduce the Off-Lable Use of Antiphschotics	Anna Militello	DON	Springfield, IL	150.00		150.00
7/31/2015	Oakton community college	activity director course	Karin Knutson	Activities Director	des plaines	458.00		458.00
7/31/2015	CE Solutions	fee for service	all staff	N/A	webinar	4,665.00		4,665.00

7/31/2015	IHCA Pac	error - should be coded to donation	John Vrba		District of Columbia	1,000.00	(1,000.00)	-
7/31/2015	Illinois Health Care Association	unknown	John Vrba	owner	Springfield, IL	35.00		35.00
7/31/2015	PointClickCare Summit 2015	PCC convention	Julie Hendrickson, Peg Runowski	ADON, MDS	Palm Desert, CA	998.00	(998.00)	-
7/8/2015	PMIC	ICD-10 books	n/a	n/a	n/a	162.31		162.31
8/31/2015	Medpass Inc	Nursing Manual	N/A	N/A	N/A	338.19		338.19
8/31/2015	AHCA/NCAL	convention	John Vrba	owner	San Antonio, Tx	750.00	(750.00)	-
8/31/2015	AHCA/NCAL	convention	Neil Glen	Administrator	San Antonio, Tx	675.00	(675.00)	-
8/31/2015	IHCA-PAC	Golf/5K	John Vrba	owner	Peoria, IL	160.00	(160.00)	-
9/14/2017	IHCA	IHCA Convention and Expo	Kristin Thrun	Administrator	Peoria, IL	825.00		825.00
9/30/2015	healthcare management solutions	Alzheimer's Unit Director and Activity Director Course	Jazmine Harris	Activities Director	Chicago, IL	450.00		450.00
10/31/2015	Fred Pryor Careertrac	The Ultimate Supervisor	Anthony Schreiber	owner	Oakbrook, IL	99.00		99.00
10/31/2015	Fred Pryor Careertrac	microsoft excel	Anthony Schreiber	owner	Oakbrook, IL	79.00		79.00
10/31/2015	Downers grove CPR	CPR	misc staff	miscellaneous nursing staff	Downers Grove	210.00		210.00
11/30/2015	NASW	LSW/LCSW Review Course	Theresa Ewing	social services director	Chicago, IL	199.00		199.00
11/30/2015	Med-Pass	manual	N/A	N/A	N/A	84.55		84.55
11/30/2015	Downers grove CPR	CPR	Maryanna Vorozhbyt	RN	Downers Grove	205.00		205.00
12/31/2015	AHCA/NCAL	Insights to Performance Excel	John Vrba	owner	District of Columbia	108.95	(108.95)	-
12/31/2015	thriving with stress	thriving with stress	confidential	confidential	Westchester, Ohio	650.00	(650.00)	-
12/31/2015	Waubonsee Community College	Food Safety Certification	john render	cook	Sugar Grove, IL	130.00		130.00
12/31/2015	Robert A. Moylan	Emotional Core Therapy	manuals	n/a	Lisle, IL	500.00		500.00
12/31/2015	PESI inc	Mastering the Treatment of Difficult Wounds	Aniltta Alex	Nurse Practioner	Schaumburg, IL	199.99		199.99
						20,871.94	(4,341.95)	16,529.99

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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 - $2,281**

(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. $ **68,157** 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. $ **306,608**
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. $ **520**

(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? **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.