FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 Healthcre 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: 1/1/2012

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 1/1/2016 to 12/31/2016 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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	74,298	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	74,298	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	4,404	12,799	30,129	47,332	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,404	12,799	30,129	47,332	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.71%

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 16,540

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [ ] 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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	612,952	67,439	2,044	682,435		682,435		682,435			1
2	Food Purchase		340,918		340,918		340,918	(1,904)	339,014			2
3	Housekeeping	473,244	39,152		512,396		512,396		512,396			3
4	Laundry	30,804	1,982	126,515	159,301		159,301		159,301			4
5	Heat and Other Utilities			168,534	168,534		168,534		168,534			5
6	Maintenance	47,686	35,473	260,225	343,384		343,384	(15,256)	328,128			6
7	Other (specify):*											7
8	TOTAL General Services	1,164,686	484,964	557,318	2,206,968		2,206,968	(17,160)	2,189,808			8
	B. Health Care and Programs											
9	Medical Director			82,512	82,512		82,512		82,512			9
10	Nursing and Medical Records	5,045,943	779,937	75,210	5,901,090		5,901,090		5,901,090			10
10a	Therapy	70,934	15,357		86,291		86,291		86,291			10a
11	Activities	109,902	9,948	1,040	120,890		120,890		120,890			11
12	Social Services	193,379			193,379		193,379		193,379			12
13	CNA Training											13
14	Program Transportation			10,271	10,271		10,271		10,271			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,420,158	805,242	169,033	6,394,433		6,394,433		6,394,433			16
	C. General Administration											
17	Administrative	122,216		389,780	511,996		511,996	(389,780)	122,216			17
18	Directors Fees											18
19	Professional Services			364,712	364,712		364,712	(113,967)	250,745			19
20	Dues, Fees, Subscriptions & Promotions			75,704	75,704		75,704	(34,995)	40,709			20
21	Clerical & General Office Expenses	519,533	70,188	1,062,016	1,651,737		1,651,737	(504,932)	1,146,805			21
22	Employee Benefits & Payroll Taxes			1,949,856	1,949,856		1,949,856		1,949,856			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,317	14,317		14,317	(750)	13,567			24
25	Other Admin. Staff Transportation			4,763	4,763		4,763	(2,369)	2,394			25
26	Insurance-Prop.Liab.Malpractice			99,027	99,027		99,027		99,027			26
27	Other (specify):*											27
28	TOTAL General Administration	641,749	70,188	3,960,175	4,672,112		4,672,112	(1,046,793)	3,625,319			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,226,593	1,360,394	4,686,526	13,273,513		13,273,513	(1,063,953)	12,209,560			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.

Burgess Square
0051847
Travel Schedule
01/01/2016 - 12/31/2016

Date	Employee	Description	Amount	Adjustment	Total
2/29/2016	john vrba	5837000 · Transportation Allowance Staff	490		490
03/31/2016	Mike Hensley	5837000 · Transportation Allowance Staff	212.22	-212	0
03/31/2016	Mike Hensley	5837000 · Transportation Allowance Staff	192.05	-192	0
03/31/2016	Mike Hensley	5837000 · Transportation Allowance Staff	245.70	-246	0
04/30/2016	john vrba	5837000 · Transportation Allowance Staff	474.12		474
06/30/2016	john vrba	5837000 · Transportation Allowance Staff	384.48		384
10/31/2016	john vrba	5837000 · Transportation Allowance Staff	353.16		353
11/29/2016	john vrba	5837000 · Transportation Allowance Staff	250.56		251
11/29/2016	Mike Hensley	5837000 · Transportation Allowance Staff	173.88	-174	0
11/29/2016	Mike Hensley	5837000 · Transportation Allowance Staff	392.58	-393	0
11/29/2016	Mike Hensley	5837000 · Transportation Allowance Staff	153.90	-154	0
11/29/2016	Mike Hensley	5837000 · Transportation Allowance Staff	154.44	-154	0
11/29/2016	Mike Hensley	5837000 · Transportation Allowance Staff	262.98	-263	0
11/29/2016	Mike Hensley	5837000 · Transportation Allowance Staff	187.38	-187	0
11/29/2016	Mike Hensley	5837000 · Transportation Allowance Staff	203.04	-203	0
11/29/2016	Mike Hensley	5837000 · Transportation Allowance Staff	191.16	-191	0
12/31/2016	john VRBA	5837000 · Transportation Allowance Staff	440.64		441
		Totals	**4,762.68**	**-2,369.33**	**2,393.35**

Facility Name & ID Number Burgess Square Healthcre Ctr #0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			177,701	177,701		177,701		177,701			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,558	43,558		43,558	(770)	42,788			32
33	Real Estate Taxes			156,396	156,396		156,396		156,396			33
34	Rent-Facility & Grounds			1,161,830	1,161,830		1,161,830		1,161,830			34
35	Rent-Equipment & Vehicles			30,560	30,560		30,560		30,560			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,570,045	1,570,045		1,570,045	(770)	1,569,275			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,887,182	1,320,133	54,027	3,261,342		3,261,342		3,261,342			39
40	Barber and Beauty Shops			25,819	25,819		25,819		25,819			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			296,279	296,279		296,279		296,279			42
43	Other (specify):*	231,462			231,462		231,462	(231,462)				43
44	**TOTAL Special Cost Centers**	2,118,644	1,320,133	376,125	3,814,902		3,814,902	(231,462)	3,583,440			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,345,237	2,680,527	6,632,696	18,658,460		18,658,460	(1,296,185)	17,362,275			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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	(1,904)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,518)	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				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	(8,169)	20		20
21	Owner or Key-Man Insurance	(6,366)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(247,689)	21		24
25	Fund Raising, Advertising and Promotional	(26,646)	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	(603,113)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (906,405)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (906,405)		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 Healthcre Ctr

ID# 0051847

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (2,738)	6	1
2	Legal Adjustment	(113,967)	19	2
3	Billing Fees	(180)	20	3
4	PR- Patient Related	(36,728)	21	4
5	Marketing Exp.	(213,145)	21	5
6	Finance Charges	(1,004)	21	6
7	Transportation Adjustment - Mktg.	(2,369)	25	7
8	Interest Income Offset	(770)	32	8
9	Marketing Salaries	(231,462)	43	9
10	Non-Allowable Education (out of State)	(750)	24	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**	(603,113)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	(1,904)	0	0	0	0	0	0	0	0	0	0	(1,904)	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	(15,256)	0	0	0	0	0	0	0	0	0	0	(15,256)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(17,160)	0	0	0	0	0	0	0	0	0	0	(17,160)	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	(389,780)	0	0	0	0	0	0	0	0	0	(389,780)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(113,967)	0	0	0	0	0	0	0	0	0	0	(113,967)	19
20	Fees, Subscriptions & Promotions	(34,995)	0	0	0	0	0	0	0	0	0	0	(34,995)	20
21	Clerical & General Office Expenses	(504,932)	0	0	0	0	0	0	0	0	0	0	(504,932)	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	(750)	0	0	0	0	0	0	0	0	0	0	(750)	24
25	Other Admin. Staff Transportation	(2,369)	0	0	0	0	0	0	0	0	0	0	(2,369)	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**	(657,013)	(389,780)	0	0	0	0	0	0	0	0	0	(1,046,793)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(674,173)	(389,780)	0	0	0	0	0	0	0	0	0	(1,063,953)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burgess Square Healthcre Ctr **#** 0051847 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	(770)	0	0	0	0	0	0	0	0	0	0	(770)	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**	(770)	0	0	0	0	0	0	0	0	0	0	(770)	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):*	(231,462)	0	0	0	0	0	0	0	0	0	0	(231,462)	43
44	**TOTAL Special Cost Centers**	(231,462)	0	0	0	0	0	0	0	0	0	0	(231,462)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(906,405)	(389,780)	0	0	0	0	0	0	0	0	0	(1,296,185)	45

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 389,780	JAM Health Partners, LLC	100.00%	$	$ (389,780)	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			$ 389,780			$	$ * (389,780)	14

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

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 231,320	21-03	1
2	Anthony Schreiber	Partner	Administrative	30.00	0	60	100.00	Draw	243,133	21-03	2
3	Michael Hensley	Partner	Marketing	26.00	0	60	100.00	Draw	208,907	21-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 683,360		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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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		750,000		Variable	43,558	6
7												7
8												8
9	TOTAL Facility Related						$	$ 750,000			$ 43,558	9
	B. Non-Facility Related*											
10	Interest Income		X								(770)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (770)	14
15	TOTALS (line 9+line14)						$	$ 750,000			$ 42,788	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 Healthcre Ctr # 0051847 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	$	156,396	2
3. Under or (over) accrual (line 2 minus line 1).	$	156,396	3
4. Real Estate Tax accrual used for 2016 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.	$	156,396	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	137,002	8
	2012	144,132	9
	2013	147,939	10
	2014	152,453	11
	2015	156,396	12

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

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burgess Square Healthcre 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-107-044	Nursing Home	$ 156,395.78	$ 156,395.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 156,395.78	$ 156,395.78

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	924	9
10	Door Exit System			2013	9,988		20	499	499	1,707	10
11	Patient Room Renovations (Flooring, Walls)			2013	36,005		20	1,800	1,800	5,850	11
12	Generator/Electric			2013	198,097		20	9,905	9,905	32,191	12
13	Electric - For Generator			2013	25,518		20	1,276	1,276	4,147	13
14	Flooring - (Lobby, Patient Rooms)			2013	70,424		20	3,521	3,521	11,150	14
15	Shower Room			2014	6,235		20	312	312	910	15
16	Flooring - (Lobby, Patient Rooms)			2014	4,950		20	248	248	620	16
17	Secure Door - Wander Guards			2014	7,048		20	352	352	851	17
18	Kitchen Floor			2014	29,268		20	1,463	1,463	3,414	18
19	HGR Soffit Replacement			2014	4,974		20	249	249	560	19
20	RAGO Electric - Downspout Heaters			2014	15,600		20	780	780	1,690	20
21	RAGO Electric 2 Additional Downspouts and Heaters			2014	1,400		20	70	70	151	21
22	Tile/Vinyl Replacement Rm 2214			2014	2,145		20	107	107	223	22
23	Tile/Vinyl Replacement Rm 2315			2014	2,445		20	122	122	254	23
24	Fire Door 500 Hallway			2014	1,075		20	54	54	112	24
25	Remodel 2500 Wing Rooms - Walls, Floors, Lighting			2014	18,900		20	945	945	1,969	25
26	Overbed Lights/Wall Switches			2014	4,677		20	234	234	468	26
27	Commercial Hot Water Heater - Dave Soltwisch Plumbing			2014	7,459		20	373	373	746	27
28	Lawn Sprinkler System			2014	21,900		20	1,095	1,095	2,190	28
29	Replace 31' 4" Cast Iron Piping - Kitchen			2014	16,700		20	835	835	1,670	29
30	Elevator Car Door Restrictors			2014	3,500		20	175	175	350	30
31	Convert 2500 Ofc/Nurses Station (Paint/Wallpaper Rms 2310,										31
32	2315,2214) Soffit			2014	4,280		20	214	214	428	32
33	Parking Lot			2014	623,718		20	31,186	31,186	62,372	33
34	Light Posts			2014	25,869		20	1,293	1,293	2,586	34
35											35
36	Book Depreciation					177,701					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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 289	$ 289	$ 482	37
38	Energy Efficient Windows All Patient Rooms West Side of Facility	2015	45,647		20	2,282	2,282	2,853	38
39	New Door Project - 2500 Wing	2015	6,071		15	405	405	742	39
40	Flooring Rm 2204- Maple Vinyl planks and Vinyl Base	2015	2,923		20	146	146	195	40
41	Roof Repair by HVAC Unit Hole/Leak Repair	2015	3,720		20	186	186	217	41
42	Electrical Life Support Panel Work	2016	3,750		20	172	172	172	42
43	New Roof Façade on Front and North Sides	2016	53,313		20	1,555	1,555	1,555	43
44	Installation of 2nd Façade including Soffit	2016	13,261		20	221	221	221	44
45	Parking Lot Stripping	2016	7,834		20	261	261	261	45
46	Custom Cabinetry/Work Counter - Administration Office	2016	2,738		20	137	137	137	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)		$ 1,292,362	$ 177,701		$ 63,020	$ 63,020	$ 144,368	70

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

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 491,329	$	$ 89,337	$ 89,337		$ 298,805	71
72	Current Year Purchases	5,847		390	390		390	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 497,176	$	$ 89,727	$ 89,727		$ 299,195	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)	$ 1,789,538	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 177,701	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,747	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,954)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 443,563	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		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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		$ 1,159,014			3
4	Additions							4
5								5
6	Storage Pods				2,816			6
7	TOTAL		203		$ 1,161,830 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 30,560 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.

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Description	Amount
Telephone Equipment	6514
Chillers	15384
Water Softner	2280
Postage Meter	1020
Ice Machine	2160
Business Internet Router	3202
	30560

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 787,791		$	$		$ 787,791	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	70,632					70,632	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	1,028,759					1,028,759	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				1,104,418		1,104,418	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					54,027	215,715		269,742	13
14	TOTAL			$ 1,887,182		$ 54,027	$ 1,320,133		$ 3,261,342	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.

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	Special Services - Supplies (Column 6 - Other)	Amount
13	Radiology Medicare- Cost	61038
13	Laboratory - Medicare -Cost	43685
13	Other Outside Service - Medicare - Cost	110992
		215715

	Special Services - Services (Column 5 - Other)	
13	Respiratory Therapy	54027
		54027

STATE OF ILLINOIS

Facility Name & ID Number Burgess Square Healthcre Ctr **#** 0051847 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 631,413	$	1
2	Cash-Patient Deposits	9,347		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,260,571		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	194,181		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	100		8
9	Other(specify): Seet Attached	330,120		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,425,732	$	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	1,253,345		15
16	Equipment, at Historical Cost	508,724		16
17	Accumulated Depreciation (book methods)	(487,915)		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)**	$ 1,274,154	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,699,886	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 863,459	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,347		28
29	Short-Term Notes Payable	750,000		29
30	Accrued Salaries Payable	135,702		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,395		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	685,391		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,457,294	$	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)**	$ 2,457,294	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,242,592	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,699,886	$	48

***(See instructions.)**

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	Other Current Assets:	Amount	Amount
9	Due from Prior Owner	29,920	
9	Option Deposit	300,000	
9	Utility Deposits	200	
9			
9			
9			
	Total Line 9	330,120	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	HSA EE Contribution	(7,600)	
36	Private Pay Holding Account	218,341	
36	BCBS Liability	16,834	
36	Accrued Occupancy Tax	95,566	
36	Due To Jam	294,750	
36			
36			
	Total Line 36	685,391	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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,656,895	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,656,895	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(414,303)	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)**	$ (414,303)	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)**	$ 2,242,592	24 *

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

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 17,806,925	1
2	Discounts and Allowances for all Levels	(8,382,724)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,424,201	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,990,110	6
7	Oxygen	64,724	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,054,834	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	1,964	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	1,092,499	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	421,947	19
20	Radiology and X-Ray	98,957	20
21	Other Medical Services	1,013,194	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,628,561	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	770	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 770	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	135,791	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 135,791	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,244,157	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,206,968	31
32	Health Care	6,394,433	32
33	General Administration	4,672,112	33
	B. Capital Expense		
34	Ownership	1,570,045	34
	C. Ancillary Expense		
35	Special Cost Centers	3,518,623	35
36	Provider Participation Fee	296,279	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,658,460	40
41	**Income before Income Taxes (line 30 minus line 40)****	(414,303)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (414,303)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 572,885	44
45	Private Pay - Net Inpatient Revenue	3,464,645	45
46	Medicare - Net Inpatient Revenue	1,460,490	46
47	Other-(specify) Insurance	3,707,595	47
48	Other-(specify) Hospice	218,586	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,424,201	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.**

Burgess Square Healthcare and Rehabilitation Centre, LLC
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Description	Amount
Credit Card Income	139
Other Income	115,303
Private Pay Refund Policy Inc.	20,349
Total	135,791

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	5,016	5,642	$ 270,319	$ 47.91	1
2	Assistant Director of Nursing	2,024	2,160	84,588	39.16	2
3	Registered Nurses	53,429	59,879	1,899,584	31.72	3
4	Licensed Practical Nurses	33,238	37,656	1,006,507	26.73	4
5	CNAs & Orderlies	96,541	115,234	1,715,434	14.89	5
6	CNA Trainees					6
7	Licensed Therapist	44,944	50,024	1,887,182	37.73	7
8	Rehab/Therapy Aides	4,214	4,667	70,934	15.20	8
9	Activity Director	317	324	7,146	22.06	9
10	Activity Assistants	6,945	7,909	102,756	12.99	10
11	Social Service Workers	6,132	6,910	193,379	27.99	11
12	Dietician	1,920	2,160	62,619	28.99	12
13	Food Service Supervisor	3,995	4,246	75,424	17.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,969	33,550	474,909	14.16	15
16	Dishwashers					16
17	Maintenance Workers	1,864	2,160	47,686	22.08	17
18	Housekeepers	28,646	32,814	473,244	14.42	18
19	Laundry	1,761	2,148	30,804	14.34	19
20	Administrator	2,320	2,904	122,216	42.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,741	20,957	519,533	24.79	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	3,523	4,019	69,511	17.30	31
32	Other Health Care(specify)					32
33	Other(specify) Dir. Mktg.	4,808	5,184	231,462	44.65	33
34	TOTAL (lines 1 - 33)	350,347	400,547	$ 9,345,237 *	$ 23.33	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	32	$ 2,044	1-3	35
36	Medical Director	Monthly	82,512	9-3	36
37	Medical Records Consultant	22	1,320	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,776	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	16	1,040	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultants	Monthly	45,444	10-3	47
48					48
49	TOTAL (lines 35 - 48)	70	$ 143,136		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	556	17,670	10-3	52
53	TOTAL (lines 50 - 52)	556	$ 17,670		53

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristin Thrun	Administrator	0	$ 92,526
Neil Glein (1/1/16-1/29/2016)	Administrator	0	29,690
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 122,216

B. Administrative - Other

Description	Amount
Management Fee - JAM Health Partners, LLC	$ 389,780
TOTAL (agree to Schedule V, line 17, col. 3)	$ 389,780
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ability/E Health Data	Data Processing	$ 11,739
It's Never 2 Late	Data Processing	2,550
NICL Lab	Data Processing	1,100
Optima Healthcare Solutions	Data Processing	5,404
PCC/Wescom	Data Processing	59,038
Telemedicine Solutions/Stratus	Data Processing	8,153
FGMK	Accounting/Consulting	71,625
Duane Morris	Legal	111,857
Grotefeld Hoffman	Legal	16,735
Myers & Fowers/Tim Wilsey	Legal	10,250
2401 Corporate	Other Professional	3,580
ADP	Payroll Processing	62,681
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 364,712

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 227,565
Unemployment Compensation Insurance	
FICA Taxes	793,561
Employee Health Insurance	678,531
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	175,452
Union 401K	44,643
Other Employee Benefits	30,104
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,949,856

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	$
Advertising: Employee Recruitment	5,979
Health Care Worker Background Check	1,000
(Indicate # of checks performed 100)	
Patient Background Checks 900	9,000
Dues 7 Subscriptions	12,489
Licenses & Fees	12,241
Advertising & Promotions	26,646
Less: Public Relations Expense	( )
Non-allowable advertising	(26,646)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,709

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	13,567
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,567

**See instructions.

Burgess Square
0051847
Seminar Schedule
01/01/2016 - 12/31/2016

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	Non-Allowable	Allowable
1/1/2016	Downers Grove CPR	CPR	misc	nursing personnel	Downers Grove, Il	30.00	`	30.00
1/5/2016	CE Solutions	fee for service	all staff	n/a	webinar	4,665.00		4,665.00
2/3/2016	Healthcare Information Network	CMS focused survey	Julie Hendrickson	Director of Nursing	Chicago, Il	199.00		199.00
2/18/2016	Pathway Health	Resorative/Rehab Certification	Darlene France	RN Supervisor	Westmont, Il	999.00		999.00
2/18/2016	Illinois Healthcare Assic/American Express	Payroll Based Journal	K Thrun/KJ Petersen	Administrator	Webinar	90.00		90.00
4/1/2016	Innerspace Environment Assessment	Food Service Manager Cert.	M Wells/M Simo	Dietary Supervisor	Elburn, Il	420.00		420.00
4/1/2016	Downers Grove CPR	CPR	misc	nursing personnel	Downers Grove, Il	160.00		160.00
4/13/2016	Illinois Healthcare Assic/American Express	IHCA Public Policy Forum	K Thrun/KJ Petersen	Administrator	Springfield, Il	75.00		75.00
4/15/2016	Illinois Medical Director Assoc/Amer Express	Conference on post-acute & long term care	John Vrba	Owner	St. Louis, Mo	100.00		100.00
4/29/2016	Mary Simo	Food handler training course	Mary Simo	Dietary Worker	webinar	9.95		9.95
4/30/2016	Downers Grove CPR	CPR	misc	nursing personnel	Downers Grove, Il	30.00		30.00
5/17/2016	Illinois Healthcare Assoc	Rehospitalization & quality measures	K Thrun/KJ Petersen	Administrator	Lisle, Il	190.00		190.00
5/8/2016	American Healthcare Association	convention	John Vrba	owner	Washington, DC	750.00	(750.00)	
5/19/2016	Medpass Inc	nursing policy procedure manual	n/a	n/a	n/a	148.05		148.05
6/4/2016	Downers Grove CPR	CPR	misc	nursing personnel	Downers Grove, Il	30.00		30.00
7/6/2016	CE Solutions	fee for service	all staff	n/a	webinar	4,956.56		4,956.56
6/28/2016	Illinois Heatlhcare/American Express	Managing social media use & privacy in nursing facilities	K. Thrun/KJ Petersen/ M Hensley	Administrator	webinar	90.00		90.00
7/13/2016	John Render	Food handler training course	John Render	Cook	webinar	9.95		9.95
9/7/2016	Illinois Healthcare Assoc/American Express	Annual Convention	J. Vrba/K Thrun/J Hendrickson	Owner/Administrator/D..O.N.	Springfield, Il	825.00		825.00
10/5/2016	Deborah White	CPR	Deborah White	C.N.A.	Downers Grove, Il	45.00		45.00
11/7/2016	Illinois Healthcare Assoc/American Express	Requirements of Participation Phase I	KJ Petersen	Administrator	webinar	75.00		75.00
10/13/2016	Aniltta Alex	Primed midwest annual conference	Aniltta Alex	Nurse practitioner	Rosemont, Il.	145.00		145.00
11/12/2016	Downers Grove CPR	CPR	misc	nursing personnel	Downers Grove, Il	180.00		180.00
12/5/2016	Medpass Inc	MDS Manual	na	na	na	94.50		94.50
							TOTAL	**13,567.01**

Burgess Square
0051847
Legal Schedule
01/01/2016-12/31/2016

Date	Vendor	Description	Debit	Non-Allowable*	Total
1/31/2016	Duane Morris, LLP	5834300 · Legal Fees	308	308	-
1/31/2016	Duane Morris, LLP	5834300 · Legal Fees	14,170	14,170	-
2/29/2016	Duane Morris, LLP	5834300 · Legal Fees	3,607	3,607	-
2/29/2016	Duane Morris, LLP	5834300 · Legal Fees	1,112	1,112	-
3/31/2016	Duane Morris, LLP	5834300 · Legal Fees	2,597	2,597	-
3/31/2016	Duane Morris, LLP	5834300 · Legal Fees	10,918	10,918	-
4/30/2016	Duane Morris, LLP	5834300 · Legal Fees	1,166	1,166	-
4/30/2016	Duane Morris, LLP	5834300 · Legal Fees	21,784	21,784	-
4/30/2016	Duane Morris, LLP	5834300 · Legal Fees	417		416.50
5/31/2016	Duane Morris, LLP	5834300 · Legal Fees	2,676	2,676	-
5/31/2016	Duane Morris, LLP	5834300 · Legal Fees	6,388	6,388	-
5/31/2016	Duane Morris, LLP	5834300 · Legal Fees	742	742	-
6/30/2016	Duane Morris, LLP	5834300 · Legal Fees	5,927	5,927	-
6/30/2016	Duane Morris, LLP	5834300 · Legal Fees	7,834	7,834	-
6/30/2016	Duane Morris, LLP	5834300 · Legal Fees	1,643	1,643	-
7/31/2016	Duane Morris, LLP	5834300 · Legal Fees	695	695	-
7/31/2016	Duane Morris, LLP	5834300 · Legal Fees	5,394		5,394.00
9/30/2016	Duane Morris, LLP	5834300 · Legal Fees	7,633	7,633	-
9/30/2016	Duane Morris, LLP	5834300 · Legal Fees	255	235	20.00
9/30/2016	Duane Morris, LLP	5834300 · Legal Fees	6,342	6,342	-
10/31/2016	Duane Morris, LLP	5834300 · Legal Fees	2,950	2,950	-
11/29/2016	Duane Morris, LLP	5834300 · Legal Fees	4,434	4,434	-
11/29/2016	Duane Morris, LLP	5834300 · Legal Fees	811	811	-
1/31/2016	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	120		120.00
1/31/2016	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	2229.9		2,229.90
3/31/2016	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	80		80.00
3/31/2016	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	6443.22		6,443.22
5/31/2016	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	640		640.00
6/30/2016	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	2175.73		2,175.73
8/31/2016	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	5046.34		5,046.34
5/31/2016	Meyers & Flowers, LLC	5834300 · Legal Fees	10000	10000	-
2/29/2016	tim wilsey	5834300 · Legal Fees	250		250.00
		Totals	**136,783**	**113,967**	**22,816**

*Adjustment to legal fees for purpose of retaining attorney client privilege.

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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-$6,347**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **66,191** 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 fo
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 Departmen
during this cost report period. $ **296,279**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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? **No** Indicate the amount. $ **0**

(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 fo
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