FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 1/1/2017 to 12/31/2017 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, Healthcare
(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: 1/1/2017 Ending: 12/31/2017

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	499	13,390	31,297	45,186	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	499	13,390	31,297	45,186	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.98%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 16,536

Medicare Intermediary Wisconsin Physician 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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	611,817	47,419	3,690	662,926		662,926		662,926			1
2	Food Purchase		337,096		337,096		337,096	(1,588)	335,508			2
3	Housekeeping	488,129	39,360		527,489		527,489		527,489			3
4	Laundry	35,595	2,020	139,696	177,311		177,311		177,311			4
5	Heat and Other Utilities			183,377	183,377		183,377		183,377			5
6	Maintenance	48,952	62,645	208,473	320,070		320,070	(19,352)	300,718			6
7	Other (specify):*											7
8	TOTAL General Services	1,184,493	488,540	535,236	2,208,269		2,208,269	(20,940)	2,187,329			8
	B. Health Care and Programs											
9	Medical Director			82,500	82,500		82,500		82,500			9
10	Nursing and Medical Records	4,848,067	747,185	165,397	5,760,649		5,760,649		5,760,649			10
10a	Therapy	70,566	12,776		83,342		83,342		83,342			10a
11	Activities	86,612	9,768	1,268	97,648		97,648		97,648			11
12	Social Services	234,720			234,720		234,720		234,720			12
13	CNA Training											13
14	Program Transportation			13,608	13,608		13,608		13,608			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,239,965	769,729	262,773	6,272,467		6,272,467		6,272,467			16
	C. General Administration											
17	Administrative	100,470		700,000	800,470		800,470	(700,000)	100,470			17
18	Directors Fees											18
19	Professional Services			231,075	231,075		231,075	(71,063)	160,012			19
20	Dues, Fees, Subscriptions & Promotions			85,572	85,572		85,572	(24,989)	60,583			20
21	Clerical & General Office Expenses	551,148	80,780	1,043,944	1,675,872		1,675,872	(459,545)	1,216,327			21
22	Employee Benefits & Payroll Taxes			1,933,944	1,933,944		1,933,944		1,933,944			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,703	17,703		17,703	(1,561)	16,142			24
25	Other Admin. Staff Transportation			5,428	5,428		5,428	(2,846)	2,582			25
26	Insurance-Prop.Liab.Malpractice			116,382	116,382		116,382		116,382			26
27	Other (specify):*											27
28	TOTAL General Administration	651,618	80,780	4,134,048	4,866,446		4,866,446	(1,260,004)	3,606,442			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,076,076	1,339,049	4,932,057	13,347,182		13,347,182	(1,280,944)	12,066,238			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
01/01/2017 - 12/31/2017

Date	Employee	Description	Amount	Adjustment	Total
3/9/2017	john vrba	5837000 - Transportation Allowance Staff	441.91		441.91
6/22/2017	kathy fuentes	5837000 - Transportation Allowance Staff	239.68		239.68
8/1/2017	Mike Hensley	5837000 - Transportation Allowance Staff	310.3	-310.3	0
8/1/2017	Mike Hensley	5837000 - Transportation Allowance Staff	242.36	-242.36	0
8/1/2017	Mike Hensley	5837000 - Transportation Allowance Staff	205.98	-205.98	0
8/1/2017	Mike Hensley	5837000 - Transportation Allowance Staff	201.16	-201.16	0
8/1/2017	Mike Hensley	5837000 - Transportation Allowance Staff	234.87	-234.87	0
8/1/2017	Mike Hensley	5837000 - Transportation Allowance Staff	284.09	-284.09	0
8/1/2017	Mike Hensley	5837000 - Transportation Allowance Staff	221.4	-221.4	0
8/11/2017	john vrba	5837000 - Transportation Allowance Staff	736.16		736.16
8/31/2017	Mike Hensley	5837000 - Transportation Allowance Staff	191	-191	0
9/1/2017	Mike Hensley	5837000 - Transportation Allowance Staff	184.58	-184.58	0
11/2/2017	john vrba	5837000 - Transportation Allowance Staff	486.85		486.85
12/8/2017	kj petersen	5837000 - Transportation Allowance Staff	72.22		72.22
12/14/2017	Mike Hensley	5837000 - Transportation Allowance Staff	383.06	-383.06	0
12/20/2017	kathy jo petersen	5837000 - Transportation Allowance Staff	72.22		72.22
12/20/2017	kathy jo petersen - Reversed	5837000 - Transportation Allowance Staff	-72.22		-72.22
12/26/2017	john vrba	5837000 - Transportation Allowance Staff	604.55		604.55
12/28/2017	Mike Hensley	5837000 - Transportation Allowance Staff	387.34	-387.34	0
		Totals	**5,427.51**	**(2,846.14)**	**2,581.37**

Facility Name & ID Number Burgess Square Healthcre Ctr #0051847 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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			168,819	168,819		168,819	(26,385)	142,434			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,445	43,445		43,445	(6,403)	37,042			32
33	Real Estate Taxes			157,789	157,789		157,789		157,789			33
34	Rent-Facility & Grounds			1,120,117	1,120,117		1,120,117		1,120,117			34
35	Rent-Equipment & Vehicles			33,221	33,221		33,221		33,221			35
36	Other (specify):*											36
37	TOTAL Ownership			1,523,391	1,523,391		1,523,391	(32,788)	1,490,603			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,834,117	1,162,443	82,973	3,079,533		3,079,533		3,079,533			39
40	Barber and Beauty Shops			27,665	27,665		27,665		27,665			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			284,956	284,956		284,956		284,956			42
43	Other (specify):*	230,084			230,084		230,084	(230,084)				43
44	TOTAL Special Cost Centers	2,064,201	1,162,443	395,594	3,622,238		3,622,238	(230,084)	3,392,154			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,140,277	2,501,492	6,851,042	18,492,811		18,492,811	(1,543,816)	16,948,995			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: 1/1/2017 Ending: 12/31/2017

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	(1,588)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,005)	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	(26,385)	30		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	(8,365)	20		20
21	Owner or Key-Man Insurance	(6,788)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(180,698)	21		24
25	Fund Raising, Advertising and Promotional	(16,444)	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	(590,543)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (843,816)		$	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))**	$ (843,816)		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: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (6,347)	6	1
2	Legal Adjustment	(71,063)	19	2
3	Billing Fees	(180)	20	3
4	PR- Patient Related	(42,373)	21	4
5	Marketing Expense	(228,427)	21	5
6	Finance Charges	(1,259)	21	6
7	Transportation Adjustment - Mktg.	(2,846)	25	7
8	Interest Income Offset	(6,403)	32	8
9	Marketing Salaries	(230,084)	43	9
10	Non-Allowable Seminar Expense	(1,561)	24	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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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**	(590,543)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,588)	0	0	0	0	0	0	0	0	0	0	(1,588)	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	(19,352)	0	0	0	0	0	0	0	0	0	0	(19,352)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,940)	0	0	0	0	0	0	0	0	0	0	(20,940)	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	(700,000)	0	0	0	0	0	0	0	0	0	(700,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(71,063)	0	0	0	0	0	0	0	0	0	0	(71,063)	19
20	Fees, Subscriptions & Promotions	(24,989)	0	0	0	0	0	0	0	0	0	0	(24,989)	20
21	Clerical & General Office Expenses	(459,545)	0	0	0	0	0	0	0	0	0	0	(459,545)	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	(1,561)	0	0	0	0	0	0	0	0	0	0	(1,561)	24
25	Other Admin. Staff Transportation	(2,846)	0	0	0	0	0	0	0	0	0	0	(2,846)	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	(560,004)	(700,000)	0	0	0	0	0	0	0	0	0	(1,260,004)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(580,944)	(700,000)	0	0	0	0	0	0	0	0	0	(1,280,944)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burgess Square Healthcre Ctr **#** 0051847 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	(26,385)	0	0	0	0	0	0	0	0	0	0	(26,385)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,403)	0	0	0	0	0	0	0	0	0	0	(6,403)	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**	(32,788)	0	0	0	0	0	0	0	0	0	0	(32,788)	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):*	(230,084)	0	0	0	0	0	0	0	0	0	0	(230,084)	43
44	**TOTAL Special Cost Centers**	(230,084)	0	0	0	0	0	0	0	0	0	0	(230,084)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(843,816)	(700,000)	0	0	0	0	0	0	0	0	0	(1,543,816)	45

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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		Mgmt. 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	$ 700,000	JAM Health Partners, LLC	100.00%	$	$ (700,000)	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			$ 700,000			$	$ * (700,000)	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: 1/1/2017 Ending: 12/31/2017

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 Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 231,513	21-03	1
2	Anthony Schreiber	Partner	Administrative	30.00	0	60	100.00	Draw	242,286	21-03	2
3	Michael Hensley	Partner	Marketing	26.00	0	60	100.00	Draw	207,962	21-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 681,761		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: 1/1/2017 Ending: 2/31/2017

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: 1/1/2017 Ending: 12/31/2017

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												6
7	Wintrust Bank		X	Working Capital	Various	5/1/13		700,000		Variable	43,445	7
8												8
9	TOTAL Facility Related						$	$ 700,000			$ 43,445	9
	B. Non-Facility Related*											
10	Interest Income		X								(6,403)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,403)	14
15	TOTALS (line 9+line14)						$	$ 700,000			$ 37,042	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:** 1/1/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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.)	$	157,789	2
3. Under or (over) accrual (line 2 minus line 1).	$	157,789	3
4. Real Estate Tax accrual used for 2017 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.	$	157,789	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	144,132	8
	2013	147,939	9
	2014	152,453	10
	2015	156,396	11
	2016	157,789	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 2016	$	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.**

2016 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 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-107-044	Nursing Home	$ 157,789.00	$ 157,789.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 157,789.00	$ 157,789.00

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 12/31/2017

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	1,181	9
10	Door Exit System			2013	9,988		20	499	499	2,206	10
11	Patient Room Renovations (Flooring, Walls)			2013	36,005		20	1,800	1,800	7,651	11
12	Generator/Electric			2013	198,097		20	9,905	9,905	42,096	12
13	Electric - For Generator			2013	25,518		20	1,276	1,276	5,422	13
14	Flooring - (Lobby, Patient Rooms)			2013	70,424		20	3,521	3,521	14,671	14
15	Shower Room			2014	6,235		20	312	312	1,221	15
16	Flooring - (Lobby, Patient Rooms)			2014	4,950		20	248	248	866	16
17	Secure Door - Wander Guards			2014	7,048		20	352	352	1,204	17
18	Kitchen Floor			2014	29,268		20	1,463	1,463	4,877	18
19	HGR Soffit Replacement			2014	4,974		20	249	249	808	19
20	RAGO Electric - Downspout Heaters			2014	15,600		20	780	780	2,470	20
21	RAGO Electric 2 Additional Downspouts and Heaters			2014	1,400		20	70	70	222	21
22	Tile/Vinyl Replacement Rm 2214			2014	2,145		20	107	107	331	22
23	Tile/Vinyl Replacement Rm 2315			2014	2,445		20	122	122	377	23
24	Fire Door 500 Hallway			2014	1,075		20	54	54	166	24
25	Remodel 2500 Wing Rooms - Walls, Floors, Lighting			2014	18,900		20	945	945	2,914	25
26	Overbed Lights/Wall Switches			2014	4,677		20	234	234	702	26
27	Commercial Hot Water Heater - Dave Soltwisch Plumbing			2014	7,459		20	373	373	1,118	27
28	Lawn Sprinkler System			2014	21,900		20	1,095	1,095	3,467	28
29	Replace 31' 4" Cast Iron Piping - Kitchen			2014	16,700		20	835	835	2,853	29
30	Elevator Car Door Restrictors			2014	3,500		20	175	175	612	30
31	Convert 2500 Ofc/Nurses Station (Paint/Wallpaper Rms 2310,										31
32	2315,2214) Soffit			2014	4,280		20	214	214	695	32
33	Parking Lot			2014	623,718		20	31,186	31,186	98,755	33
34	Light Posts			2014	25,869		20	1,293	1,293	4,096	34
35											35
36	Book Depreciation					168,819					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: 1/1/2017 Ending: 12/31/2017

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	$ 770	37
38	Energy Efficient Windows All Patient Rooms West Side of Facility	2015	45,647		20	2,282	2,282	5,135	38
39	New Door Project - 2500 Wing	2015	6,071		15	304	304	860	39
40	Flooring Rm 2204- Maple Vinyl planks and Vinyl Base	2015	2,923		20	146	146	341	40
41	Roof Repair by HVAC Unit Hole/Leak Repair	2015	3,720		20	186	186	403	41
42	Electrical Life Support Panel Work	2016	3,750		20	188	188	359	42
43	New Roof Façade on Front and North Sides	2016	53,313		20	2,666	2,666	4,221	43
44	Installation of 2nd Façade including Soffit	2016	13,261		20	663	663	884	44
45	Parking Lot Stripping	2016	7,834		20	522	522	870	45
46	Custom Cabinetry/Work Counter - Administration Office	2016	2,738		20	137	137	216	46
47	Heating Unit - Facility	2017	11,700		20	585	585	585	47
48	Window Project - Facility	2017	6,347		20	185	185	185	48
49	Hot Water Heater - Facility	2017	25,319		20	527	527	527	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)		$ 1,335,728	$ 168,819		$ 66,046	$ 66,046	$ 216,337	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: 1/1/2017 Ending: 12/31/2017

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	$ 497,176	$	$ 75,325	$ 75,325		$ 374,324	71
72	Current Year Purchases	15,950		1,063	1,063		1,063	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 513,126	$	$ 76,388	$ 76,388		$ 375,387	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)	$ 1,848,854	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 168,819	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 142,434	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (26,385)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 591,724	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: 1/1/2017 Ending: 12/31/2017

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		$ 1,117,128			3
4	Additions							4
5								5
6	Storage Pods				2,989			6
7	TOTAL		203		$ 1,120,117 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 33,221 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.

Burgess Square Healthcare and Rehabilitation Centre, LLC
0051847
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1/1/16-12/31/16

Description	Amount
Telephone Equipment	9573
Chillers	15384
Water Softner	2280
Postage Meter	622
Ice Machine	2160
Business Internet Router	3202
	33221

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 12/31/2017

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	$ 790,029		$	$		$ 790,029	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	72,179					72,179	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	971,909					971,909	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				957,554		957,554	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					82,973	204,889		287,862	13
14	TOTAL			$ 1,834,117		$ 82,973	$ 1,162,443		$ 3,079,533	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	78,581
13	Laboratory - Medicare -Cost	48,124
13	Other Outside Service - Medicare - Cost	78,184
		204,889

	Special Services - Services (Column 5 - Other)	
13	Respiratory Therapy	82,973
		82,973

STATE OF ILLINOIS

Facility Name & ID Number Burgess Square Healthcre Ctr **#** 0051847 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 558,623	$	1
2	Cash-Patient Deposits	5,291		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,200,383		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	349,988		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	100		8
9	Other(specify): See Attached	330,120		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,444,505	$	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	1,290,364		15
16	Equipment, at Historical Cost	512,974		16
17	Accumulated Depreciation (book methods)	(656,734)		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)**	$ 1,146,604	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,591,109	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 650,044	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,291		28
29	Short-Term Notes Payable	700,000		29
30	Accrued Salaries Payable	163,140		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,251		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	716,307		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,251,033	$	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)**	$ 2,251,033	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,340,076	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,591,109	$	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	(8,400)	
36	Private Pay Holding Account	248,839	
36	BCBS Liability	34,983	
36	Accrued Sales Tax	422	
36	Accrued Occupancy Tax	69,736	
36	Due To Jam	294,750	
36	Accrued 401K	31,477	
36	Due to JAM -IH	(23,000)	
	Total Line 36	716,307	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: 1/1/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,242,592	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,242,592	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	97,484	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)**	$ 97,484	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)**	$ 2,340,076	24 *

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

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,188,988	1
2	Discounts and Allowances for all Levels	(7,840,191)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,348,797	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,835,874	6
7	Oxygen	56,535	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,892,409	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	1,588	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	974,699	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	335,644	19
20	Radiology and X-Ray	71,618	20
21	Other Medical Services	959,119	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,342,668	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,403	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,403	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	18	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,590,295	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,208,269	31
32	Health Care	6,272,467	32
33	General Administration	4,866,446	33
	B. Capital Expense		
34	Ownership	1,523,391	34
	C. Ancillary Expense		
35	Special Cost Centers	3,337,282	35
36	Provider Participation Fee	284,956	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,492,811	40
41	**Income before Income Taxes (line 30 minus line 40)****	97,484	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 97,484	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 78,134	44
45	Private Pay - Net Inpatient Revenue	3,860,402	45
46	Medicare - Net Inpatient Revenue	2,291,076	46
47	Other-(specify) Insurance	3,959,727	47
48	Other-(specify) Hospice	159,458	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,348,797	49

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

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

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

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

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Description	Amount
Credit Card Income	18
Total	18

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	3,544	4,130	$ 233,793	$ 56.61	1
2	Assistant Director of Nursing	1,904	2,080	85,546	41.13	2
3	Registered Nurses	54,723	58,515	1,749,510	29.90	3
4	Licensed Practical Nurses	27,103	29,676	987,990	33.29	4
5	CNAs & Orderlies	99,036	107,955	1,723,881	15.97	5
6	CNA Trainees					6
7	Licensed Therapist	42,754	46,952	1,834,117	39.06	7
8	Rehab/Therapy Aides	4,000	4,498	70,566	15.69	8
9	Activity Director	1,849	2,011	33,486	16.65	9
10	Activity Assistants	4,107	4,489	53,126	11.83	10
11	Social Service Workers	8,379	9,005	234,720	26.07	11
12	Dietician	2,000	2,406	67,490	28.05	12
13	Food Service Supervisor	5,693	6,223	77,498	12.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,075	29,852	466,829	15.64	15
16	Dishwashers					16
17	Maintenance Workers	1,816	2,080	48,952	23.53	17
18	Housekeepers	27,330	31,701	488,129	15.40	18
19	Laundry	2,045	2,314	35,595	15.38	19
20	Administrator	1,864	2,080	100,470	48.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,152	20,053	551,148	27.48	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	3,318	3,780	67,347	17.82	31
32	Other Health Care(specify)					32
33	Other(specify)	4,736	4,992	230,084	46.09	33
34	TOTAL (lines 1 - 33)	341,428	374,792	$ 9,140,277 *	$ 24.39	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	$ 3,690	1-3	35
36	Medical Director	Monthly	82,500	9-3	36
37	Medical Records Consultant	18	1,080	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,780	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	28	1,268	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	PhysicianConsultants	Monthly	27,500	10-3	47
48					48
49	TOTAL (lines 35 - 48)	102	$ 129,818		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	270	$ 14,696	10-3	50
51	Licensed Practical Nurses	141	7,281	10-3	51
52	Certified Nurse Assistants/Aides	1,380	34,511	10-3	52
53	TOTAL (lines 50 - 52)	1,791	$ 56,488		53

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristin Thrun	Administrator	0	$ 100,470
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,470

B. Administrative - Other

Description	Amount
	$
Management Fee - Jam Health Partners, LLC	700,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 700,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
DS/I Tech Automation	Data Processing	737
It's Never Too Late	Data Processing	2,763
Optima Healthcare Solutions	Data Processing	5,621
ADP	Payroll	62,291
Telemedicine Solutions/Stratus	Data Processing	6,995
FGMK, LLC	Accounting/Consulting	56,693
Duane Morris	Legal	13,657
Grotefeld Hoffman	Legal	14,394
One Beacon/Schwartz/Premier	Legal	60,185
Pryor/Vanek Larson & Kolb	Legal	7,739
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 231,075

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 223,548
Unemployment Compensation Insurance	
FICA Taxes	765,086
Employee Health Insurance	706,787
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	175,452
Union 401K	41,420
Other Employee Benefits	21,651
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,933,944

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	17,490
Health Care Worker Background Check	910
(Indicate # of checks performed 91)	
Patient Background Checks 309	3,090
Licenses & Fees	19,462
Dues & Subscriptions	15,651
Advertisisng & Promotions	16,444
Less: Public Relations Expense	( )
Non-allowable advertising	(16,444)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 60,583

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	16,142
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,142

* Attach copy of IMRF notifications

**See instructions.

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Seminar Schedule

01/01/2017 - 12/31/2017

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	Non-Allowable	Allowable
1/10/2017	rehab connections	PT eval codes	Lyndon Lao	Director of Therapy	Homer Glen, Il	99		99.00
1/12/2017	CE Solutions	Monthly inservices	all staff	all	on line	4,956.56		4,956.56
1/30/2017	Downers Grove CPR	CPR certification	Asha Rao	COTA	Downers Grove, Il	30		30.00
2/20/2017	Mike Hensley	Dignity Therapy	Mike Hensley	owner	online	30.95	(30.95)	-
2/27/2017	Mike Hensley	SNF performance for Medicare population	Mike Hensley	owner	online	240	(240.00)	-
3/8/2017	Downers Grove CPR	CPR certification	Donna Kossman	PTA	Downers Grove, Il	90		90.00
		CPR certification	A Cashill	RN	Downers Grove, Il			
		CPR certification	R Poca	C.N.A.	Downers Grove, Il			
3/8/2017	AMERICAN EXPRESS	(See below)						
		Building future of Nursing Science	Aniltta Alex	Nurse Practitioner	Oakbrook Terrace, IL	$125.00		125.00
		Reasoning with unreasonable people	John Vrba	owner	Oakbrook, Il	$79.00		79.00
3/16/2017	karen styrna	CPR certification	Karen Styrna	C.N.A.	Downers Grove, Il	50		50.00
5/4/2017	Rajeev Kumar	Lab Director CME course	Rajeev Kumar	Medical Director	online	525		525.00
5/8/2017	AMERICAN EXPRESS	(See below)						
		AHCA convention	John Vrba	owner	Las Vegas, NV	750.00	(750.00)	-
		Consolidated billing	Kathy Fuentes	Asst Office Manager	Iowa City, Iowa	50.00		50.00
		LSVT Loud	Kelly Byron	speech therapist	online	580.00		580.00
5/15/2017	Downers Grove CPR	CPR certification	Teresita Martinez	C.N.A.	Downers Grove, Il	40		40.00
6/7/2017	AMERICAN EXPRESS	5 star pain quality measures	John Vrba	owner	online	55		55.00
6/27/2017	CE Solutions	Monthly inservices	all staff	all	online	4,956.56		4,956.56
7/1/2017	Downers Grove CPR	CPR certification	Amanda Trujillo	LPN	Downers Grove, Il	40		40.00
7/7/2017	AMERICAN EXPRESS	(See below)						
		Participation-bringing them to life	John Vrba/Kristin Thrun	owner/administrator	Hillside, Ill	250.00		250.00
		Infection preventionist certifcation	Kristin Thrun/Julie Hendrickson	administrator/D.O.N.	online	900.00		900.00
8/4/2017	Downers Grove CPR	CPR certification	Jacey Credo	C.N.A.	Downers Grove, Il	40		40.00
8/8/2017	AMERICAN EXPRESS	AHCA convention	KJ Petersen	Administrator	Las Vegas, NV	525	(525.00)	-
8/17/2017	claudette dyer	C.N.A. Course	Claudette Dyer	C.N.A.	River Grove, Il	1,135.00		1,135.00
8/31/2017	Cash	Food Handler Course	K Bakken/M Gazaferi	Dietary aides	on line	19.9		19.90
9/1/2017	Downers Grove CPR	CPR certification	J. Hamrin/D. Mampuzhackalon	RN	Downers Grove, Il	160		160.00
		CPR certification	J. Sabugga/B Puthankudy	C.N.A./LPN	Downers Grove, Il			
9/7/2017	AMERICAN EXPRESS	IHCA convention	John Vrba	owner	Springfield, Il	795		795.00
10/8/2017	AMERICAN EXPRESS	SNF PPS 2018 Final Rule	Kj Petersen/C Phistry	Administrator/OT	Rolling Meadows, Il	398		398.00
		Illinois Medical Director Conference	John Vrba	owner	Oak Brook, Il	75		75.00
10/19/2017	Downers Grove CPR	CPR certification	Connie Phistry	OT	Downers Grove, Il	40		40.00
10/20/2017	performance health	Seating/Positioning	Ashley Rupe	OT	Warrenville, Il	129		129.00
10/26/2017	Mike Hensley	Village of Westmont Address	Mike Hensley	owner	Westmont, Il	15	(15.00)	-
11/17/2017	chelsea hermanson	CPR certification	Chelsea Hermanson	RN	Chicago, Il	65		65.00
12/12/2017	oakton community college	Activity Director Course	rebecca Vrba	Psychosocial	Skokie, Il.	459		459.00
					TOTAL	17,702.97	(1,560.95)	**16,142.02**

Burgess Square

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Legal Schedule

01/01/2016-12/31/2016

Date	Vendor	Description	Debit	Non-Allowable*	Total
10/2/2017	Allen N. Schwartz, Ltd.	5834300 · Legal Fees	15000		15000
1/20/2017	Duane Morris, LLP	5834300 · Legal Fees	69.5	-69.5	0
1/20/2017	Duane Morris, LLP	5834300 · Legal Fees	1296		1296
2/10/2017	Duane Morris, LLP	5834300 · Legal Fees	1507.5		1507.5
3/21/2017	Duane Morris, LLP	5834300 · Legal Fees	681	-681	0
3/21/2017	Duane Morris, LLP	5834300 · Legal Fees	395.5		395.5
4/24/2017	Duane Morris, LLP	5834300 · Legal Fees	1532.5		1532.5
4/24/2017	Duane Morris, LLP	5834300 · Legal Fees	740	-740	0
5/8/2017	Duane Morris, LLP	5834300 · Legal Fees	1087	-1087	0
6/15/2017	Duane Morris, LLP	5834300 · Legal Fees	296	-296	0
6/15/2017	Duane Morris, LLP	5834300 · Legal Fees	543	-543	0
7/19/2017	Duane Morris, LLP	5834300 · Legal Fees	123.5	-123.5	0
7/19/2017	Duane Morris, LLP	5834300 · Legal Fees	192.5	-192.5	0
7/19/2017	Duane Morris, LLP	5834300 · Legal Fees	5000		5000
11/17/2017	Duane Morris, LLP	5834300 · Legal Fees	192.5	-192.5	0
6/13/2017	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	3252.5	-3252.5	0
8/7/2017	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	2612.51	-2612.51	0
8/22/2017	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	2865	-2865	0
10/24/2017	Grotefeld Hoffman Schleiter Gordon & Och	5834300 · Legal Fees	5664	-5664	0
3/13/2017	OneBeacon Insurance Group	5834300 · Legal Fees	8882.77	-8882.77	0
4/17/2017	OneBeacon Insurance Group	5834300 · Legal Fees	1899.24	-1899.24	0
6/5/2017	OneBeacon Insurance Group	5834300 · Legal Fees	6115.51	-6115.51	0
6/14/2017	OneBeacon Insurance Group	5834300 · Legal Fees	2725.87	-2725.87	0
7/17/2017	OneBeacon Insurance Group	5834300 · Legal Fees	1270.08	-1270.08	0
9/13/2017	OneBeacon Insurance Group	5834300 · Legal Fees	2911.42	-2911.42	0
11/27/2017	Premier Claims Management, LLC	5834300 · Legal Fees	21380	-21380	0
10/31/2017	ray pryor, p.c.	5834300 · Legal Fees	2500	-2500	0
7/13/2017	vanek, larson & kolb LLC	5834300 · Legal Fees	180		180
9/1/2017	Vanek, Larson & Kolb LLC	5834300 · Legal Fees	44	-44	0
10/30/2017	Vanek, Larson & Kolb LLC	5834300 · Legal Fees	400	-400	0
11/30/2017	Vanek, Larson & Kolb LLC	5834300 · Legal Fees	3129.06	-3129.06	0
11/30/2017	Vanek, Larson & Kolb LLC	5834300 · Legal Fees	1430.52	-1430.52	0
12/29/2017	Vanek, Larson & Kolb LLC	5834300 · Legal Fees	56	-56	0
		Totals	95974.98	-71063.48	24911.5

Facility Name & ID Number Burgess Square Healthcre Ctr # 0051847 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 - $8706**

(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. $ **61,863** 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. $ **284,956**
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