		FOR BHF USE					

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0051847

Facility Name: Burgess Square Hlthcare Ctr

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

County: DuPage

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

HFS ID Number:

Date of Initial License for Current Owners: 1/12/2012

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 B. 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 1/1/2020 to 12/31/2020 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) 940-3269 Fax # (847) 964-5469

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	5,122	6,354	19,112	30,588	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,122	6,354	19,112	30,588	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 41.17%

D. How many bed reserve days during this year were paid by the Department?
None (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 1/7/2020 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 14,262

Medicare Intermediary Wisconsin Pysicians Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	580,400	45,506	2,760	628,666		628,666		628,666			1
2	Food Purchase		265,894		265,894		265,894	(235)	265,659			2
3	Housekeeping	495,391	38,460		533,851		533,851		533,851			3
4	Laundry		2,740	155,277	158,017		158,017		158,017			4
5	Heat and Other Utilities			155,975	155,975		155,975		155,975			5
6	Maintenance	91,225	42,398	278,243	411,866		411,866	(13,354)	398,512			6
7	Other (specify):*											7
8	TOTAL General Services	1,167,016	394,998	592,255	2,154,269		2,154,269	(13,589)	2,140,680			8
	B. Health Care and Programs											
9	Medical Director			42,750	42,750		42,750		42,750			9
10	Nursing and Medical Records	4,565,906	628,929	133,800	5,328,635		5,328,635		5,328,635			10
10a	Therapy	65,042	5,004		70,046		70,046		70,046			10a
11	Activities	24,241	1,472	918	26,631		26,631		26,631			11
12	Social Services	235,417			235,417		235,417		235,417			12
13	CNA Training											13
14	Program Transportation			95	95		95		95			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,890,606	635,405	177,563	5,703,574		5,703,574		5,703,574			16
	C. General Administration											
17	Administrative	193,931		165,000	358,931		358,931	(165,000)	193,931			17
18	Directors Fees											18
19	Professional Services			267,575	267,575		267,575	(41,586)	225,989			19
20	Dues, Fees, Subscriptions & Promotions			69,650	69,650		69,650	(7,307)	62,343			20
21	Clerical & General Office Expenses	506,828	37,975	1,235,008	1,779,811		1,779,811	(635,852)	1,143,959			21
22	Employee Benefits & Payroll Taxes			1,579,271	1,579,271		1,579,271		1,579,271			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,799	9,799		9,799		9,799			24
25	Other Admin. Staff Transportation			466	466		466	(466)				25
26	Insurance-Prop.Liab.Malpractice			275,666	275,666		275,666		275,666			26
27	Other (specify):*											27
28	TOTAL General Administration	700,759	37,975	3,602,435	4,341,169		4,341,169	(850,211)	3,490,958			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,758,381	1,068,378	4,372,253	12,199,012		12,199,012	(863,800)	11,335,212			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Burgess Square Hlthcare Ctr #0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			181,884	181,884		181,884	765,885	947,769			30
31	Amortization of Pre-Op. & Org.							23,250	23,250			31
32	Interest			9,920	9,920		9,920	526,371	536,291			32
33	Real Estate Taxes							177,106	177,106			33
34	Rent-Facility & Grounds			1,086,091	1,086,091		1,086,091	(1,062,581)	23,510			34
35	Rent-Equipment & Vehicles			36,080	36,080		36,080		36,080			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,313,975	1,313,975		1,313,975	430,031	1,744,006			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,446,109	762,221	91,570	2,299,900		2,299,900		2,299,900			39
40	Barber and Beauty Shops			3,857	3,857		3,857		3,857			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			209,272	209,272		209,272		209,272			42
43	Other (specify):* Dir. Of Mktg.	208,647			208,647		208,647	(208,647)				43
44	**TOTAL Special Cost Centers**	1,654,756	762,221	304,699	2,721,676		2,721,676	(208,647)	2,513,029			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,413,137	1,830,599	5,990,927	16,234,663		16,234,663	(642,416)	15,592,247			45

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(235)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,354)	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	(51,305)	30		9
10	Interest and Other Investment Income	(929)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance	(7,069)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(358,318)	21		24
25	Fund Raising, Advertising and Promotional	(717)	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	(537,504)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (969,681)		$	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))**	$ (969,681)		37

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

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

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

Burgess Square Hlthcare Ctr

ID# 0051847

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Public Relations - Patient Related	$ (12,247)	21	1
2	Legal Fee Adjustment	(51,586)	19	2
3	Finance Charges	(26)	21	3
4	Bank Fees	(13,097)	21	4
5	Marketing Expense	(245,095)	21	5
6	Marketing Salaries	(208,647)	43	6
7	Non-Allowable IHCA Lobbying/PAC Dues	(5,551)	20	7
8	Non-Allowable Chamber Dues	(609)	20	8
9	Non-Allowable Billing Fees	(180)	20	9
10	Transportation Marketing	(466)	25	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**	(537,504)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(235)	0	0	0	0	0	0	0	0	0	0	(235)	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	(13,354)	0	0	0	0	0	0	0	0	0	0	(13,354)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,589)	0	0	0	0	0	0	0	0	0	0	(13,589)	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	(165,000)	0	0	0	0	0	0	0	0	0	(165,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(51,586)	10,000	0	0	0	0	0	0	0	0	0	(41,586)	19
20	Fees, Subscriptions & Promotions	(7,307)	0	0	0	0	0	0	0	0	0	0	(7,307)	20
21	Clerical & General Office Expenses	(635,852)	0	0	0	0	0	0	0	0	0	0	(635,852)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(466)	0	0	0	0	0	0	0	0	0	0	(466)	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**	(695,211)	(155,000)	0	0	0	0	0	0	0	0	0	(850,211)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(708,800)	(155,000)	0	0	0	0	0	0	0	0	0	(863,800)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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	(51,305)	817,190	0	0	0	0	0	0	0	0	0	765,885	30
31	Amortization of Pre-Op. & Org.	0	23,250	0	0	0	0	0	0	0	0	0	23,250	31
32	Interest	(929)	527,300	0	0	0	0	0	0	0	0	0	526,371	32
33	Real Estate Taxes	0	177,106	0	0	0	0	0	0	0	0	0	177,106	33
34	Rent-Facility & Grounds	0	(1,062,581)	0	0	0	0	0	0	0	0	0	(1,062,581)	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**	(52,234)	482,265	0	0	0	0	0	0	0	0	0	430,031	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):*	(208,647)	0	0	0	0	0	0	0	0	0	0	(208,647)	43
44	**TOTAL Special Cost Centers**	(208,647)	0	0	0	0	0	0	0	0	0	0	(208,647)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(969,681)	327,265	0	0	0	0	0	0	0	0	0	(642,416)	45

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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%	None		JAM Health Partners, LLC		Mgmt. Co.
Anthomy Schreiber	30%			JAM Insurance Holdings, LLC		Holding Co.
Michael Hensley	26%			JAM Realty & Property Management, LLC		Bldg. Ptrshp.

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	$ 165,000	JAM Health Partners, LLC		$	$ (165,000)	1
2	V	34	Rent	1,062,581	JAM Realty & Property Management, LLC			(1,062,581)	2
3	V	30	Depreciation		JAM Realty & Property Management, LLC		817,190	817,190	3
4	V	33	Real Estate Tax Expense		JAM Realty & Property Management, LLC		177,106	177,106	4
5	V	32	Interest Expense		JAM Realty & Property Management, LLC		527,300	527,300	5
6	V	19	Professional Fees		JAM Realty & Property Management, LLC		10,000	10,000	6
7	V	31	Amortization		JAM Realty & Property Management, LLC		23,250	23,250	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,227,581			$ 1,554,846	$ * 327,265	14

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	None	40	60.00	Draw	$ 227,382	21-3	1
2	Anthony Schreiber	Partner	Administrative	30.00	None	40	100.00	Draw	237,013	21-3	2
3	Michael Hensley	Partner	Marketing	26.00	None	40	100.00	Draw	0*	21-3	3
4											4
5	Marketing expense has been adjusted from this report on page 5										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 464,395		13

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

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIBC		X	Mortgage	$66,580.00	1/2021	$ 11,625,000	$ 11,420,000			$ 527,300	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC		X	Working Capital - LOC			2,000,000				9,920	6
7												7
8												8
9	TOTAL Facility Related				$66,580.00		$ 13,625,000	$ 11,420,000			$ 537,220	9
	B. Non-Facility Related*											
10	Interest Income		X								(929)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (929)	14
15	TOTALS (line 9+line14)						$ 13,625,000	$ 11,420,000			$ 536,291	15

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

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

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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.)		$ 177,106	2
3. Under or (over) accrual (line 2 minus line 1).		$ 177,106	3
4. Real Estate Tax accrual used for 2020 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.		$ 177,106	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	156,396	8
	2016	157,789	9
	2017	160,301	10
	2018	168,596	11
	2019	177,106	12

Building was purchased in 2020 and real estate taxes were paid as part of closing

Real estate tax escrow will be insutituted for 2021 Cost Report.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burgess Square Hlthcare Ctr COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0051847

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

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

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-107-044	Long-Term Care Property	$ 177,106.18	$ 177,106.18
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 177,106.18	$ 177,106.18

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [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: 116,250
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 23,250
4. Dates Incurred:

Nature of Costs: Organization Costs - Building Purchase
(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	Facility		2020	$ 620,000	1
2					2
3	TOTALS			$ 620,000	3

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	203		2020		$ 8,013,702	$ 817,190	39	$ 205,480	$ (611,710)	$ 205,480	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2013	345,187		20	17,259	17,259	125,006	9
10	Various			2014	802,143		20	40,107	40,107	248,078	10
11	Various			2015	64,136		20	3,207	3,207	17,130	11
12	Electrical Life Support Panel Work			2016	3,750		20	188	188	922	12
13	New Roof Façade on Front and North Sides			2016	53,313		20	2,666	2,666	12,218	13
14	Installation of 2nd Façade including Soffit			2016	13,261		20	663	663	3,173	14
15	Parking Lot Stripping			2016	7,834		20	522	522	2,437	15
16	Custom Cabinetry/Work Counter - Administration Office			2016	2,738		20	137	137	628	16
17	Heating Unit - Facility			2017	11,700		20	585	585	2,340	17
18	Window Project - Facility			2017	6,347		20	317	317	1,137	18
19	Hot Water Heater - Facility			2017	25,319		20	1,266	1,266	4,325	19
20	Indoor Transfer Switch - Electric Panel			2018	13,975		20	699	699	2,038	20
21	Jeron Provider 7900 Nurse Call System - All Rooms			2018	296,895		20	14,845	14,845	16,975	21
22	New Concrete Areas - Main Entrance, Rear Patio, and rear of building			2019	13,600		20	680	680	1,247	22
23	for main trash dumpster										23
24	2 New AC/ Units Rooftop			2019	71,599		20	3,580	3,580	5,370	24
25	Red Link Therm			2019	15,425		20	771	771	1,092	25
26	2 New Roof Curbs			2019	21,241		20	1,062	1,062	1,239	26
27	Parking Lot Sewer/asphualt /stripping			2020	17,785		20	593	593	593	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	Book Depreciation					181,884					36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,799,950	$ 999,074		$ 294,627	$ (522,563)	$ 651,428	70

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

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 533,949	$	$ 40,271	$ 40,271	5-10	$ 488,320	71
72	Current Year Purchases	8,708		1,161	1,161	5	1,161	72
73	Fully Depreciated Assets							73
74	Bldg. Partnership Alloc.	3,786,298		611,710	611,710		611,710	74
75	TOTALS	$ 4,328,955	$	$ 653,142	$ 653,142		$ 1,101,191	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)	$ 14,748,905	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 999,074	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 947,769	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (51,305)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,752,619	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 Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 36,080 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Description	Amount
Telephone Equipment	12067
Chillers	15384
Water Softner	2280
Postage Meter	1113
Ice Machine	2256
Business Internet Router	2980
	36080

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

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	$ 600,965		$	$		$ 600,965	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	65,845					65,845	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	779,299					779,299	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				573,881		573,881	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached	39-2					188,340		188,340	12
13	Other (specify): See Attached	39-3				91,570			91,570	13
14	TOTAL			$ 1,446,109		$ 91,570	$ 762,221		$ 2,299,900	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.

Burgess Square Healthcare and Rehabilitation Centre, LLC
0051847
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	Special Services - Supplies (Column 6 - Other)	Amount
13	Radiology Medicare- Cost	39,985
13	Laboratory - Medicare -Cost	102,378
13	Other Outside Service - Medicare - Cost	45,977
		188,340

	Special Services - Services (Column 5 - Other)	Amount
13	Respiratory Therapy	63,317
13	RT Supplies	7,919
13	Equipment Rental RT	20,334
		91,570

STATE OF ILLINOIS

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,058,594	$ 2,178,618	1
2	Cash-Patient Deposits	21,218	21,218	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,072,963	1,072,963	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	408,407	408,407	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	519,000	522,512	8
9	Other(specify): See Attached	130	130	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,080,312	$ 4,203,848	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		620,000	13
14	Buildings, at Historical Cost		8,013,702	14
15	Leasehold Improvements, at Historical Cost	1,443,989	1,443,989	15
16	Equipment, at Historical Cost	840,090	4,626,388	16
17	Accumulated Depreciation (book methods)	(1,213,854)	(2,031,044)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		179,492	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)**	$ 1,070,225	$ 12,852,527	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,150,537	$ 17,056,375	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 726,792	$ 726,792	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,218	21,218	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	252,692	252,692	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,081	21,081	31
32	Accrued Real Estate Taxes(Sch.IX-B)		159,004	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	211,492	1,030,492	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,233,275	$ 2,211,279	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,420,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,999,448	1,999,448	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,999,448	$ 13,419,448	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,232,723	$ 15,630,727	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,917,814	$ 1,425,648	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,150,537	$ 17,056,375	48

***(See instructions.)**

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	Other Current Assets:	Amount	Amount
9			
9	EE Loans and Advances	(70)	(70)
9	Utility Deposits	200	200
9			
9			
9			
	Total Line 9	130	130

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

	Other Current Liabilities:	Amount	Amount
36	Accrued Vacation	67,500	67,500
36	HSA EE Contribution	(8,400)	(8,400)
36	Private Pay Holding Account	75,764	75,764
36	BCBS Liability	10,698	10,698
36	Accrued Sales Tax	201	201
36	Accrued Occupancy/Bed Tax	20,455	20,455
36	Due To Jam Realty	3,512	3,512
36	Accrued 401K	41,762	41,762
36	Due to JAM Healthcare Partners - Deposit		300,000
36	Due to Burgess Square - Pension	-	519,000
	Total Line 36	211,492	1,030,492

	Other Non-Current Liabilities:	Amount	Amount
43	Pension Fund Liability	345,548	345,548
43	Note Payable SBA-CARES ACT	1,655,900	1,655,900
43			
43			
43			
43			
43			
43			
	Total Line 43	2,001,448	2,001,448

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,087,501	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,087,503	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(169,689)	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)**	$ (169,689)	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)**	$ 1,917,814	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,232,259	1
2	Discounts and Allowances for all Levels	(5,320,196)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,912,063	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,743,074	6
7	Oxygen	32,446	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,775,520	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	235	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	629,708	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	202,745	19
20	Radiology and X-Ray	38,195	20
21	Other Medical Services	742,742	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,613,625	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	929	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 929	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,762,837	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,762,837	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,064,974	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,154,269	31
32	Health Care	5,703,574	32
33	General Administration	4,341,169	33
	B. Capital Expense		
34	Ownership	1,313,975	34
	C. Ancillary Expense		
35	Special Cost Centers	2,512,404	35
36	Provider Participation Fee	209,272	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,234,663	40
41	**Income before Income Taxes (line 30 minus line 40)****	(169,689)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (169,689)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 33,014	44
45	Private Pay - Net Inpatient Revenue	1,958,773	45
46	Medicare - Net Inpatient Revenue	4,236,617	46
47	Other-(specify) Insurance	2,683,659	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,912,063	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	47
Other Income	1,764,560
Maketing Income	(1,770)
Total	1,762,837

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	1,888	2,080	$ 94,822	$ 45.59	1
2	Assistant Director of Nursing	1,904	2,080	90,926	43.71	2
3	Registered Nurses	58,419	62,801	2,156,110	34.33	3
4	Licensed Practical Nurses	13,645	15,128	446,724	29.53	4
5	CNAs & Orderlies	81,797	91,438	1,702,409	18.62	5
6	CNA Trainees					6
7	Licensed Therapist	31,242	36,100	1,446,109	40.06	7
8	Rehab/Therapy Aides	3,020	3,565	65,042	18.24	8
9	Activity Director					9
10	Activity Assistants	1,462	1,829	24,241	13.25	10
11	Social Service Workers	6,683	7,551	235,417	31.18	11
12	Dietician	1,880	1,968	59,203	30.08	12
13	Food Service Supervisor	3,696	3,936	45,789	11.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,229	25,400	475,408	18.72	15
16	Dishwashers					16
17	Maintenance Workers	3,029	3,684	91,225	24.76	17
18	Housekeepers	24,125	28,221	495,391	17.55	18
19	Laundry					19
20	Administrator	3,688	3,784	193,931	51.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,126	16,724	506,828	30.31	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	3,257	3,831	74,915	19.55	31
32	Other Health Care(specify)					32
33	Other(specify) Mktg.	4,114	4,471	208,647	46.67	33
34	TOTAL (lines 1 - 33)	281,204	314,591	$ 8,413,137 *	$ 26.74	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	50	$ 2,760	1-3	35
36	Medical Director	Monthly	42,750	9-3	36
37	Medical Records Consultant	7	455	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	29,123	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	20	918	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultants	Monthly	24,000	10-3	47
48	EHR/MDS	Monthly	79,286	10-3	48
49	TOTAL (lines 35 - 48)	77	$ 179,292		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	10	$ 568	10-3	50
51	Licensed Practical Nurses	10	368	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	20	$ 936		53

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KJ Petersen	Administrator	0	$ 101,919
Kristin Thrun	Administrator	0	92,012
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 193,931

B. Administrative - Other

Description	Amount
Management Fee - JAM Health Partners, LLC	$ 165,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 165,000

C. Professional Services

Vendor/Payee	Type	Amount
Direct Supply	Data Processing	$ 5,252
It's Never Too Late	Data Processing	876
Optima Healthcare Solutions	Data Processing	5,690
Stratus Video/Telemedicine Sol.	Data Processing	6,999
FGMK, LLC	Accounting/Tax/Consulting	104,325
Duane Morris, LLP	Legal	35,110
One Beacon/Medpro Group	Legal	32,161
Monahan Law Group	Legal	6,456
ADP	Payroll	57,410
Scott & Kraus/Brian Stines	Legal	1,536
2401 Inc./Engineering Assoc.	Consultants	3,390
Baldrige Coaching	Quality Consulting	8,370
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 267,575

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 171,574
Unemployment Compensation Insurance	
FICA Taxes	655,088
Employee Health Insurance	693,214
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union 401K	39,583
Other Employee Benefits	19,812
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,579,271

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	20,877
Health Care Worker Background Check	
(Indicate # of checks performed 60)	600
Patient Background Checks 675	6,750
Dues & Subscriptions	13,841
Licenses & Fees	20,275
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 62,343

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,799
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,799

* Attach copy of IMRF notifications

**See instructions.

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Legal Schedule
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Date	Vendor	Description	Debit	Non-Allowable*	Total
1/1/2020	Reverse PY Accrual	5834300 · Legal Fees	-60,001.00		-60,001.00
7/31/2020	Brian A Stines, P.C.	5834300 · Legal Fees	200.00	-200.00	0.00
7/31/2020	Brian A Stines, P.C.	5834300 · Legal Fees	200.00	-200.00	0.00
1/31/2020	Duane Morris, LLP	5834300 · Legal Fees	3,151.00		3,151.00
1/31/2020	Duane Morris, LLP	5834300 · Legal Fees	960.50		960.50
1/31/2020	Duane Morris, LLP	5834300 · Legal Fees	47,452.84		47,452.84
2/29/2020	Duane Morris, LLP	5834300 · Legal Fees	476.00		476.00
2/29/2020	Duane Morris, LLP	5834300 · Legal Fees	5,127.96		5,127.96
3/31/2020	Duane Morris, LLP	5834300 · Legal Fees	595.00		595.00
4/30/2020	Duane Morris, LLP	5834300 · Legal Fees	1,572.50		1,572.50
5/31/2020	Duane Morris, LLP	5834300 · Legal Fees	1,272.04		1,272.04
5/31/2020	Duane Morris, LLP	5834300 · Legal Fees	11,757.24		11,757.24
6/30/2020	Scott & Kraus, LLC	5834300 · Legal Fees	1,135.80		1,135.80
7/31/2020	Duane Morris, LLP	5834300 · Legal Fees	1,436.50		1,436.50
7/31/2020	Duane Morris, LLP	5834300 · Legal Fees	535.50		535.50
8/31/2020	Duane Morris, LLP	5834300 · Legal Fees	357.00		357.00
8/31/2020	Duane Morris, LLP	5834300 · Legal Fees	85.00		85.00
10/31/2020	Duane Morris, LLP	5834300 · Legal Fees	654.50		654.50
10/31/2020	Duane Morris, LLP	5834300 · Legal Fees	4,039.50		4,039.50
11/30/2020	Duane Morris, LLP	5834300 · Legal Fees	119.00		119.00
11/30/2020	Duane Morris, LLP	5834300 · Legal Fees	1,275.00		1,275.00
12/31/2020	Duane Morris, LLP	5834300 · Legal Fees	476.00		476.00
12/31/2020	Duane Morris, LLP	5834300 · Legal Fees	1,200.00		1,200.00
10/31/2020	Duane Morris, LLP - dec 2019	5834300 · Legal Fees	12,568.50	-12,568.50	0.00
11/30/2020	Medical Protective Company	5834300 · Legal Fees	1,442.00	-1,442.00	0.00
5/31/2020	MedPro Group	5834300 · Legal Fees	1,016.40	-1,016.40	0.00
8/31/2020	MedPro Group	5834300 · Legal Fees	9,875.50	-9,875.50	0.00
5/31/2020	Monahan Law Group, LLC	5834300 · Legal Fees	3,224.17	-3,224.17	0.00
5/31/2020	Monahan Law Group, LLC	5834300 · Legal Fees	(645.00)	645.00	0.00
6/30/2020	Monahan Law Group, LLC	5834300 · Legal Fees	1,201.00	-1,201.00	0.00
9/30/2020	Monahan Law Group, LLC	5834300 · Legal Fees	2,676.00	-2,676.00	0.00
1/31/2020	OneBeacon Insurance Group	5834300 · Legal Fees	8,960.53	-8,960.53	0.00
1/31/2020	OneBeacon Insurance Group	5834300 · Legal Fees	6,380.92	-6,380.92	0.00
3/31/2020	OneBeacon Insurance Group	5834300 · Legal Fees	4,485.87	-4,485.87	0.00
	Totals		75,263.77	-51,585.89	23,677.88

Burgess Square Healthcare and Rehabilitation Centre

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SEMINAR EXPENSE

1/1/2020 - 12/31/2020

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	Non-Allowable	Allowable
1/17/2020	Illinois Healthcare Assoc/American exprress	PDPM	Kelli McKirdie	MDS coordinator	on line	55		55
1/24/2020	Illinios Healthcare Association	PDPM	Kelli McKirdie	MDS coordinator	on line	55		55
1/31/2020	Illinois Healthcare Association	PDPM	Kelli McKirdie	MDS coordinator	on line	55		55
2/3/2020	CE Solutions	Monthly inservice-all staff	all staff	all staff	on line	7140		7140
8/7/2020	Academy of Nutrition and Dietetics/Am Express	Nutional Care Manual	Catherine Theodorou	Dietician	web subscription	144.99		144.99
9/7/2020	American healthcare Assoc/American Express	Infection Control Specialized Training	Darlene Franco	Director of Nursing	On line	450		450
9/7/2020	American healthcare Assoc/American Express	Infection Control Specialized Training	Chelsea Hacker	Nursing Supervisor	on line	450		450
9/7/2020	American healthcare Assoc/American Express	ACHA Convention	Mike Hensley	Owner	on line	699		699
10/8/2020	Illinois Healthcare Assoc/American exprress	IHCA Convention	John Vrba	Owner	on line	750		750
							0	9798.99
							Non-Allowable	
							Total Seminar	9798.99

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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/AHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **5-10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **41,057** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **209,272**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **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 for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **LN 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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.