

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0051847

Facility Name: Burgess Square Hlthcare Ctr

Address: 5801 South Cass Ave Westmont 60559
Number City 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
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
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 1/1/2025 to 12/31/2025 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) FG MK, 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
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)			<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,095</u>	<u>7</u>

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	2,205	2,345	2,556	90	5,208	22,534	11,104	46,042	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,205	2,345	2,556	90	5,208	22,534	11,104	46,042	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 62.14%

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 1/12/2012

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 1/7/2020 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 203

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Burgess Square Hlthcare Ctr # 0051847 Report Period Beginning: 1/1/2025 Ending: 12/31/2025
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	676,942	57,801		734,743		734,743		734,743			1
2	Food Purchase		495,437		495,437		495,437		495,437			2
3	Housekeeping	714,483	72,021		786,504		786,504		786,504			3
4	Laundry		3,077	307,225	310,302		310,302		310,302			4
5	Heat and Other Utilities			230,138	230,138		230,138		230,138			5
6	Maintenance	123,476	174,166	377,626	675,268		675,268	(14,839)	660,429			6
7	Other (specify):*											7
8	TOTAL General Services	1,514,901	802,502	914,989	3,232,392		3,232,392	(14,839)	3,217,553			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	7,700,756	855,351	737,106	9,293,213		9,293,213		9,293,213			10
10a	Therapy	29,332	4,506		33,838		33,838		33,838			10a
11	Activities	172,927	9,387		182,314		182,314		182,314			11
12	Social Services	242,794			242,794		242,794		242,794			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,145,809	869,244	759,106	9,774,159		9,774,159		9,774,159			16
	C. General Administration											
17	Administrative	205,931		517,980	723,911		723,911		723,911			17
18	Directors Fees											18
19	Professional Services			557,615	557,615		557,615	(140,000)	417,615			19
20	Dues, Fees, Subscriptions & Promotions			152,876	152,876		152,876	(7,304)	145,572			20
21	Clerical & General Office Expenses	971,191	116,708	1,499,851	2,587,750		2,587,750	(757,897)	1,829,853			21
22	Employee Benefits & Payroll Taxes			2,223,160	2,223,160		2,223,160		2,223,160			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,986	8,986		8,986		8,986			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			375,129	375,129		375,129	134,400	509,529			26
27	Other (specify):*											27
28	TOTAL General Administration	1,177,122	116,708	5,335,597	6,629,427		6,629,427	(770,801)	5,858,626			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,837,832	1,788,454	7,009,692	19,635,978		19,635,978	(785,640)	18,850,338			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			16,432	16,432		16,432	407,381	423,813			30
31	Amortization of Pre-Op. & Org.							6,310	6,310			31
32	Interest							975,507	975,507			32
33	Real Estate Taxes							231,591	231,591			33
34	Rent-Facility & Grounds			1,524,000	1,524,000		1,524,000	(1,524,000)				34
35	Rent-Equipment & Vehicles			52,351	52,351		52,351		52,351			35
36	Other (specify):*											36
37	TOTAL Ownership			1,592,783	1,592,783		1,592,783	96,789	1,689,572			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,040,360	1,211,365	169,569	3,421,294		3,421,294		3,421,294			39
40	Barber and Beauty Shops			24,397	24,397		24,397		24,397			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			389,185	389,185		389,185		389,185			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	2,040,360	1,211,365	583,151	3,834,876		3,834,876		3,834,876			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	12,878,192	2,999,819	9,185,626	25,063,637		25,063,637	(688,851)	24,374,786			45

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

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				4
5	Telephone, TV & Radio in Resident Rooms	(15,189)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,256)	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	(9,261)	21		21
22	Special Legal Fees & Legal Retainers	(140,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(442,793)	21		24
25	Fund Raising, Advertising and Promotional	(1,464)	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	(311,433)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (923,646)		\$	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)	234,795		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 234,795		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (688,851)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (162)	20	1
2	Other Expenses Related to Lobbying Activities	(5,240)	20	2
3	Marketing Expense Adjustment	(253,522)	21	3
4	Non-allowable billing fees	(188)	20	4
5	PR - Patient Related	(52,321)	21	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
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	(311,433)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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

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.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,524,000	JAM Realty & Property Management, LLC		\$	(1,524,000)	1
2	V	30	Depreciation		JAM Realty & Property Management, LLC		407,381	407,381	2
3	V	33	Real Estate Tax Expense		JAM Realty & Property Management, LLC		231,591	231,591	3
4	V	32	Interest Expense		JAM Realty & Property Management, LLC		978,763	978,763	4
5	V	19	Professional Fees		JAM Realty & Property Management, LLC				5
6	V	31	Amortization		JAM Realty & Property Management, LLC		6,310	6,310	6
7	V	26	Insurance		JAM Realty & Property Management, LLC		134,400	134,400	7
8	V	6	Repairs and Maintenance		JAM Realty & Property Management, LLC		350	350	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,524,000			\$ 1,758,795	\$ * 234,795	14

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

VII. RELATED PARTIES (continued)

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.

☐ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1					JAM Health Partners, LLC		Mgmt. Co.	1
2					JAM Insurance Holdings, LLC		Holding Co.	2
3					JAM Realty & Property Management, LLC		Bldg. Ptrshp.	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

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Vrba	Partner	Administrative	44.00	None	30	40.00	Draw	\$ 225,032	21-3	1
2	Anthony Schreiber	Partner	Administrative	30.00	None	40	100.00	Draw	237,407	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 expenses on this cost report on Page 5.										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 462,439		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: 1/1/2025 Ending: 2/31/2025

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☒
- 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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: 1/1/2025 Ending: 2/31/2025

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 ☐
- 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

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	Walker & Dunlop (HUD)		X	Mortgage			\$	13,339,244			\$	978,763	1
2	(JAM Realty & Property Mgmt)												2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	13,339,244			\$	978,763	9
	B. Non-Facility Related*												
10	Interest Income		X									(3,256)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(3,256)	14
15	TOTALS (line 9+line14)						\$	13,339,244			\$	975,507	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	216,133	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.)				\$	231,591	2
3. Under or (over) accrual (line 2 minus line 1).				\$	15,458	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	216,133	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.				\$	231,591	7
Assessed Value from Real Estate Tax Bill:	2024	3,374,356	8			
Real Estate Tax Bill for Calendar Year:	2020	182,807	9			
	2021	186,221	10			
	2022	192,686	11			
	2023	209,837	12			
	2024	218,402	13			
Real Estate Tax Accrual =1.03% of 2023 real Estate tax bill as Real Estate taxes are Escrowed as part of HUD Mortgage						
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

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.

2024 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 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 09-15-107-044	Long-Term Care Property	\$ 218,401.80	\$ 218,401.80
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 218,401.80	\$ 218,401.80

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:57,000
- B. General Construction Type:ExteriorBrickFrameSteelNumber of Stories2
- 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. List the bed capacity for the building if it differs from the licensed total.
- G. Have you properly capitalized all major repairs and equipment purchases?
- H. Are you presently operating under a sale and leaseback arrangement?

N/A
- I. Are you presently operating under a sublease agreement?

No
- J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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
- K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

X

 YES NO

If so, please complete the following:
1. Total Amount Incurred:220,886

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:6,310

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 | 2 | 3 | 4 | |
|----------|----------|-------------|---------------|-----------|---|
| | Use | Square Feet | Year Acquired | 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:

1/1/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	203		2020		\$ 8,056,651	\$	39	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		2013		345,187		20			9
10	Various		2014		802,143		20			10
11	Various		2015		6,413		20			11
12	Various		2016		80,896		20			12
13	Various		2017		43,366		20			13
14	Various		2018		310,870		20			14
15	Various		2019		121,865		20			15
16	Parking Lot Sewer/Asphalt/Stripping		2020		17,785		20			16
17	Sprinkler Service LSC Survey Compliance		2021		32,081		20			17
18	New Elevator #2		2024		134,995		27.5			18
19	Gas Shut Off Valves - Roof		2025		13,133		27.5			19
20	Roof		2025		520,200		27.5			20
21	Rooftop Curbing		2025		13,225		27.5			21
22	80 Gallon Water Heater		2025		12,133		5			22
23	Fire Panel		2025		30,880		15			23
24	Flooring for patient rooms 2216 and 407		2025		13,631		15			24
25	Flooring for patient rooms 303, 305, 307, and 308		2025		15,066		15			25
26	Flooring, Shower and Bath room 315		2025		16,357		15			26
27	Flooring Patient Rooms 304 and 310		2025		9,168		15			27
28	Roof		2025		96,312		20			28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	Current Depreciation					423,813		423,813		6,881,320

*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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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)		\$ 10,692,357	\$ 423,813		\$ 423,813	\$	\$ 6,881,320	70

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

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	\$ 657,885	\$	\$	\$	5-15	\$	71
72	Current Year Purchases	33,532				5-15		72
73	Fully Depreciated Assets							73
74	Building Partnership Equipment	3,059,871				5		74
75	TOTALS	\$ 3,751,288	\$	\$	\$		\$	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	15,063,645
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	423,813
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	423,813
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	6,881,320

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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.

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:
- *

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: \$52,351
- 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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

Burgess Square Healthcare and Rehabilitation Centre, LLC
0051847
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1/1/2025-12/31/2025

[illegible]

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

☒ 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		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	\$ 868,108		\$	\$		\$ 868,108	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	86,381					86,381	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	1,085,871					1,085,871	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				965,756		965,756	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached	39-2					245,609		245,609	12
13	Other (specify): See Attached	39-3				169,569			169,569	13
14	TOTAL			\$ 2,040,360		\$ 169,569	\$ 1,211,365		\$ 3,421,294	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Special Services - Supplies (Column 6 - Other)	Amount
13 Radiology Medicare- Cost	\$ 69,300
13 Laboratory - Medicare -Cost	\$ 126,789
13 Other Outside Service - Medicare - Cost	\$ 49,520
	<u>\$ 245,609</u>

Special Services - Services (Column 5 - Other)	Amount
13 Respiratory Therapy	\$ 122,340
13 RT Supplies	\$ 16,058
13 Equipment Rental RT	\$ 31,171
	<u>\$ 169,569</u>

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,978,694	\$ 3,123,627	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (301,276))	3,431,258	3,431,258	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	402,720	402,720	6
7	Other Prepaid Expenses	(5,965)	(5,965)	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	1,339,883	1,749,311	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,146,590	\$ 8,700,951	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		9,573,729	14
15	Leasehold Improvements, at Historical Cost	96,312	812,793	15
16	Equipment, at Historical Cost	955,318	4,922,826	16
17	Accumulated Depreciation (book methods)	(881,435)	(6,881,320)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	3,173,533	3,173,533	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,343,728	\$ 12,221,561	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,490,318	\$ 20,922,512	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 667,800	\$ 667,800	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	632,427	632,427	30
31	Accrued Taxes Payable (excluding real estate taxes)	53,440	53,440	31
32	Accrued Real Estate Taxes(Sch.IX-B)		229,322	32
33	Accrued Interest Payable		74,986	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,900,332	2,997,146	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,253,999	\$ 4,655,121	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,019,693	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,500,987	1,500,987	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,500,987	\$ 14,520,680	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,754,986	\$ 19,175,801	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,735,332	\$ 1,746,711	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,490,318	\$ 20,922,512	48

*(See instructions.)

Other Current Assets:	Amount	Amount
9 Due From JAM Realty - Pension	\$ 519,000	\$ 519,000
9 Due from JAM Realty - Loan Fees	\$ 93,175	\$ 93,175
9 Credit Union	\$ 810	\$ 810
9 HAS EE Contribution	\$ 8,400	\$ 8,400
9 Employee Transportation	\$ 43	\$ 43
9 EE Loans and Advances	\$ (70)	\$ (70)
9 Utility Deposits	\$ 30,200	\$ 30,200
9 Due to JAM	\$ 600,000	\$ 600,000
9 Due to JAM Realty	\$ 76,488	\$ 76,488
9 Union Dues Payable	\$ 11,837	\$ 11,837
9 Escrow Deposits	\$ -	\$ 183,811
9 Replacement Reserve	\$ -	\$ 225,617
9	\$ -	\$ -
9	\$ -	\$ -
	\$ -	\$ -
Total Line 9	\$ 1,339,883	\$ 1,749,311

Other Non-Current Assets:	Amount	Amount
23 Right of Use Asset	5,033,859	5,033,859
23 Accumulated Depreciation - Right of Use Asset	(2,008,872)	(2,008,872)
23 Other Assets		
23 ROU Asset - JAM Realty - Offset Related Party		
23 A/D ROU Asset - Offset related Party		
23 Deposit on Fixed Assets	148,546	148,546
23		
Total Line 23	\$3,173,533.00	\$3,173,533.00

Other Current Liabilities:	Amount	Amount
36 Accrued Vacation	\$ 67,500	\$ 67,500
36 Lease Liability ST	\$ 1,524,000	\$ 1,524,000
36 Private Pay Holding Account	\$ 80,879	\$ 80,879
36 Accrued 401K Match	\$ 71,285	\$ 71,285
36 Accrued Occupancy Tac	\$ 118,004	\$ 118,004
36 BCBS Liability	\$ 38,664	\$ 38,664
36 Current Portion of Mortgage	\$ -	\$ 108,151
36 Due to JAM Healthcare Partners - Deposit	\$ -	\$ 300,000
36 Due to/From Burgess	\$ -	\$ 169,663
36 Due to Burgess Square - Pension	\$ -	\$ 519,000
Total Line 36	\$ 1,900,332	\$ 2,997,146

Other Non-Current Liabilities:	Amount	Amount
43 Lease Liability - LT	\$ 1,500,987	\$ 1,588,987
43 Offset Related Party Lease Liability - LT	\$ -	\$ (2,855,249)
43		
43		
43		
43		
43		
43		
Total Line 43	\$ 1,500,987	\$ (1,266,262)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,117,957	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,117,957	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	580,945	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	36,430	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)	\$ 617,375	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)	\$ 6,735,332	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Burgess Square Hlthcare Ctr

0051847

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 25,591,992	1
2	Discounts and Allowances for all Levels	(12,612,629)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,979,363	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,638,219	6
7	Oxygen	137,920	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,776,139	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,047,477	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	361,218	19
20	Radiology and X-Ray	47,840	20
21	Other Medical Services	2,973,735	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,430,270	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,256	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,256	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Credit Card Income	130	28
28a	Other Income	455,424	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 455,554	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 25,644,582	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,232,392	31
32	Health Care	9,774,159	32
33	General Administration	6,629,427	33
	B. Capital Expense		
34	Ownership	1,592,783	34
	C. Ancillary Expense		
35	Special Cost Centers	3,445,691	35
36	Provider Participation Fee	389,185	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 25,063,637	40
41	Income before Income Taxes (line 30 minus line 40)**	580,945	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 580,945	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 184,283.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,313,891.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer	33,115.00	47
48	Private Pay	2,158,362.00	48
49	Medicare Part A	4,282,078.00	49
50	Other-(specify) Insurance	5,007,634.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,979,363	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,152	3,483	\$ 146,586	\$ 42.09	1
2	Assistant Director of Nursing	2,819	3,041	156,811	51.57	2
3	Registered Nurses	30,536	69,307	3,018,694	43.56	3
4	Licensed Practical Nurses	14,133	34,631	1,234,194	35.64	4
5	CNAs & Orderlies	101,739	127,881	3,082,615	24.11	5
6	CNA Trainees					6
7	Licensed Therapist	44,700	50,258	2,069,692	41.18	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,920	2,080	55,211	26.54	9
10	Activity Assistants	5,104	5,690	117,716	20.69	10
11	Social Service Workers	15,909	17,478	242,794	13.89	11
12	Dietician	1,952	2,080	84,656	40.70	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,661	28,971	592,286	20.44	15
16	Dishwashers					16
17	Maintenance Workers	6,076	6,602	123,476	18.70	17
18	Housekeepers	28,699	33,450	714,483	21.36	18
19	Laundry					19
20	Administrator	3,170	3,218	205,931	63.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,105	20,441	971,191	47.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,896	2,321	61,856	26.65	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	304,571	410,932	\$ 12,878,192 *	\$ 31.34	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	22,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	32,881	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	Physician Consultants		75,000	10-3	48
49	TOTAL (lines 35 - 48)		\$ 129,881		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	803	\$ 66,250	10-3	50
51	Licensed Practical Nurses	3,223	233,670	10-3	51
52	Certified Nurse Assistants/Aides	7,658	329,305	10-3	52
53	TOTAL (lines 50 - 52)	11,684	\$ 629,225		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberBurgess Square Hlthcare Ctr# 0051847Report Period Beginning:1/1/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathy Jo Petersen	Administartor	0	\$ 133,257
Kristin Thrun	Administartor	0	72,674
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 205,931

B. Administrative - Other

Description	Amount
JAM Health Partners, LLC	\$ 517,980
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Direct Supply	Data Processing	\$ 1,680
Informed Medical	Patient/Family Communication	4,965
Inovalon	Data Processing	15,091
Net Health Systems	Data Processing	8,469
Point Click Care	MDS/EMR	117,365
Telemedicine Solutions	Telemedicine	3,699
Wound Solutions AI, LLC	Data Processing	225
FGMK, LLC	Accounting/Tax/Consulting	142,142
ADP	Payroll	100,853
Various (See Legal Supp)	Legal	163,126
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 557,615

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$
Unemployment Compensation Insurance	
FICA Taxes	999,239
Employee Health Insurance	900,328
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	175,452
Union 401K	72,823
Other Employee Benefiits	26,978
Employee Life Dental Vision	13,516
Employee Benefits	34,824
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	63,244
Health Care Worker Background Check (Indicate # of checks performed)	3,946
Patient Background Checks	
Association Dues (total from pg 22, #4)	11,820
Dues & Subscriptions	2,760
Licenses and Fees	69,204
Less: Public Relations Expense	()
PAC and Lobbying payments	(5,402)
All non-allowable advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	8,986
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 8,986

* Attach copy of IMRF notifications

**See instructions.

Burgess Square
0051847
Legal Schedule
1/1/2025-12/31/2025

Date	Vendor	G/L Account	Decription	Amount	Non-Allowal	Total
01/15/25	Duane Morris, LLP	5834300	Legal Fees	4,672.00	(4,672.00)	0.00
01/15/25	Duane Morris, LLP	5834300	Legal Fees	16,815.00	(16,815.00)	0.00
02/13/25	Midwest Insurance	5834300	Legal Fees	12,440.46	(12,440.46)	0.00
02/20/25	Duane Morris, LLP	5834300	Legal Fees	2,389.50	0.00	2,389.50
02/20/25	Duane Morris, LLP	5834300	Legal Fees	417.50	0.00	417.50
02/20/25	Duane Morris, LLP	5834300	Legal Fees	335.00	0.00	335.00
02/27/25	Midwest Insurance	5834300	Legal Fees	8,001.28	(8,001.28)	0.00
02/28/25	Midwest Insurance	5834300	Legal Fees	6,286.09	(6,286.09)	0.00
03/24/25	Duane Morris, LLP	5834300	Legal Fees	13,005.32	(13,005.32)	0.00
03/24/25	Duane Morris, LLP	5834300	Legal Fees	18,576.00	(18,576.00)	0.00
03/24/25	Duane Morris, LLP	5834300	Legal Fees	918.50	(918.50)	0.00
04/11/25	Duane Morris, LLP	5834300	Legal Fees	34,170.70	(34,170.70)	0.00
04/11/25	Duane Morris, LLP	5834300	Legal Fees	2,627.50	(2,627.50)	0.00
05/05/25	Midwest Insurance	5834300	Legal Fees	12,559.54	(12,559.54)	0.00
05/13/25	A/Z Health & Elder Law LLC	5834300	Legal Fees	1,000.00	(1,000.00)	0.00
05/16/25	Duane Morris, LLP	5834300	Legal Fees	2,268.00	(2,154.27)	113.73
05/16/25	Duane Morris, LLP	5834300	Legal Fees	584.50	0.00	584.50
05/16/25	Duane Morris, LLP	5834300	Legal Fees	11,058.00	0.00	11,058.00
06/03/25	Vanek, Larson & Kolb LLC	5834300	Legal Fees	54.50	(54.50)	0.00
06/17/25	Duane Morris, LLP	5834300	Legal Fees	1,169.00	(1,169.00)	0.00
06/17/25	Duane Morris, LLP	5834300	Legal Fees	640.00	(640.00)	0.00
07/02/25	Vanek, Larson & Kolb LLC	5834300	Legal Fees	463.50	(463.50)	0.00
07/09/25	Duane Morris, LLP	5834300	Legal Fees	3,668.50	(3,668.50)	0.00
08/03/25	Brian A Stines, P.C.	5834300	Legal Fees	358.06	0.00	358.06
08/04/25	Vanek, Larson & Kolb LLC	5834300	Legal Fees	296.69	(296.69)	0.00
09/07/25	Midwest Insurance	5834300	Legal Fees	590.00	0.00	590.00
10/03/25	Midwest Insurance	5834300	Legal Fees	1,447.00	0.00	1,447.00
11/04/25	Vanek, Larson & Kolb LLC	5834300	Legal Fees	296.69	(79.46)	217.23
11/04/25	Vanek, Larson & Kolb LLC	5834300	Legal Fees	296.69	(296.69)	0.00
11/04/25	Midwest Insurance	5834300	Legal Fees	3,889.00	0	3,889.00
12/02/25	Vanek, Larson & Kolb LLC	5834300	Legal Fees	105.00	-105	0.00
12/02/25	Vanek, Larson & Kolb LLC	5834300	Legal Fees	296.69	0.00	296.69
12/03/25	Midwest Insurance	5834300	Legal Fees	385.00	0.00	385.00
12/03/25	Midwest Insurance	5834300	Legal Fees	962.50	0.00	962.50
12/03/25	Midwest Insurance	5834300	Legal Fees	82.50	0	82.50
Totals				163,126.21	#####	23,126.21

Burgess Square Healthcare and Rehabilitation Centre
0051847
SEMINAR EXPENSE
1/1/2025-12/31/2025

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	Non-Allowable	Allowable
2/15/2025	CE Solutions	Online Education	All Staff	All Departments	online	3612		3612
7/31/2025	CE Solutions	Online Education	All Staff	All Departments	online	3628		3628
1/8/2025	Nutrition Care Manual	Dietary Manual	Dietician	Dietician	online	363		363
5/8/2025	Med-Pass	Nursing Policy and Proce	Nursing Staff	Nursing Admin	Westmont, IL	519		519
8/8/2025	AAPACN	Post Acute Care	Kelli McBride	Nursing	online	864		864
						8986	Total Seminar	8,986.00

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	2,178
HEALTH CARE COUNCIL OF IL (HCCI)	4,240
IL HEALTHCARE ASSOCIATION (IHCA)	
	6,418 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	1,000
HEALTH CARE COUNCIL OF IL (HCCI)	4,240
IL HEALTHCARE AS	162
	5,402 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	3,178
HEALTH CARE COUNCIL OF IL (HCCI)	8,480
IL HEALTHCARE AS	162
	11,820 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 95,624 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 389,185

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ Has any meal income been offset against related costs?

No Indicate the amount. \$ N/A
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

LN 14

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: N/A

No
- (14)

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

Yes
- (15)

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.