



Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR

# 0029199 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 \_\_\_\_\_

	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	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,325	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,555	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			5,762	5,762	8
9	SNF/PED					9
10	ICF	30,498	21,464		51,962	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,498	21,464	5,762	57,724	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.40%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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 12/01/84

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/01/84 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 74 and days of care provided 5,687

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **BURGESS SQUARE HEALTHCARE CTR** # **0029199** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

**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
	<b>A. General Services</b>										
1	Dietary	387,293	28,171	22,193	437,657		437,657		437,657		1
2	Food Purchase		323,473		323,473		323,473	(1,435)	322,038		2
3	Housekeeping	372,362	79,569		451,931		451,931		451,931		3
4	Laundry	91,352	34,166	6,375	131,893		131,893		131,893		4
5	Heat and Other Utilities			196,637	196,637		196,637		196,637		5
6	Maintenance	95,539	43,121	29,707	168,367		168,367		168,367		6
7	Other (specify):*			9,649	9,649		9,649		9,649		7
8	<b>TOTAL General Services</b>	<b>946,546</b>	<b>508,500</b>	<b>264,561</b>	<b>1,719,607</b>		<b>1,719,607</b>	<b>(1,435)</b>	<b>1,718,172</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,943,712	176,954	231,355	3,352,021		3,352,021		3,352,021		10
10a	Therapy	204,935	7,388		212,323		212,323		212,323		10a
11	Activities	158,599	15,031	2,476	176,106		176,106		176,106		11
12	Social Services	275,016			275,016		275,016		275,016		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,582,262</b>	<b>199,373</b>	<b>242,831</b>	<b>4,024,466</b>		<b>4,024,466</b>		<b>4,024,466</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	108,655		201,915	310,570		310,570	(35,915)	274,655		17
18	Directors Fees										18
19	Professional Services			56,318	56,318		56,318	18,609	74,927		19
20	Dues, Fees, Subscriptions & Promotions			67,946	67,946		67,946	(15,379)	52,567		20
21	Clerical & General Office Expenses	252,683	52,710	55,302	360,695		360,695		360,695		21
22	Employee Benefits & Payroll Taxes			981,714	981,714		981,714	(20,761)	960,953		22
23	Inservice Training & Education			5,019	5,019		5,019		5,019		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,171	1,171		1,171		1,171		25
26	Insurance-Prop.Liab.Malpractice			159,165	159,165		159,165		159,165		26
27	Other (specify):*							13,064	13,064		27
28	<b>TOTAL General Administration</b>	<b>361,338</b>	<b>52,710</b>	<b>1,528,550</b>	<b>1,942,598</b>		<b>1,942,598</b>	<b>(40,382)</b>	<b>1,902,216</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,890,146</b>	<b>760,583</b>	<b>2,035,942</b>	<b>7,686,671</b>		<b>7,686,671</b>	<b>(41,817)</b>	<b>7,644,854</b>		<b>29</b>

\*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 PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	13,138
	REPAIRS & MAINTENANCE	9,055
		0
		22,193
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	6,375
		0
		6,375
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	40,200
	ELECTRICITY	103,536
	WATER	48,027
	CABLE TV - LOBBY	4,874
		0
		196,637
6	<b>MAINTENANCE</b>	
	GROUND MAINTENANCE	7,626
	PAINTING & DECORATING	591
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	11,400
	ELEVATOR MAINTENANCE & REPAIR	7,343
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,702
	FIRE SERVICE	45
		0
		0
		0
		0
		29,707
7	<b>OTHER</b>	
	SCAVENGER	8,759
	SECURITY SERVICE	890
		0
		0
		9,649
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	210,282
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,184
	PHARMACY CONSULTANT XVIII B 39-2	1,889
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	15,000
		0
		0
		231,355
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,476
		0
		2,476
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	201,915
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	7,137
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	49,181
		0
		56,318
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	13,833
	EMPLOYEE WANT ADS / RECRUITMENT XIX F	40,738
	CONTRIBUTIONS VI 20 XIX F	450
	DUES & SUBSCRIPTIONS XIX F	902
	LICENSES & PERMITS XIX F	3,913
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	896
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	200
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	7,014
	PATIENT BACKGROUND CHECKS XIX F	0
		67,946
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	498
	EQUIPMENT REPAIR & MAINTENANCE	2,021
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	6,720
	TELEPHONE	45,366
	MESSENGER SERVICE	697
		0
		55,302

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	373,140
	UNEMPLOYMENT COMPENSATION XIX D	54,887
	WORKERS COMPENSATION INSURANC XIX D	125,707
	HOSPITALIZATION INSURANCE XIX D	363,360
	EMPLOYEE BENEFITS - OTHER XIX D	43,859
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	20,761
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		981,714
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	5,019
		5,019
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	1,171
		1,171
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	159,165
		159,165
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

2,035,942

**BURGESS SQUARE HEALTHCARE CTR  
SCHEDULES  
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	323,473
LESS SALES TAX	<u>(1,435)</u>
NET FOOD	322,038

TOTAL PATIENT CENSUS	57,724
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	173,172

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	173,172
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	173,172

NET FOOD	322,038
DIVIDE TOTAL MEALS/YEAR	<u>173,172</u>

COST PER MEAL	1.86
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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Facility Name & ID Number **BURGESS SQUARE HEALTHCARE CTR**

#0029199

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			54,286	54,286		54,286	42,155	96,441			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,912	14,912		14,912	(7,344)	7,568			32
33	Real Estate Taxes			121,257	121,257		121,257		121,257			33
34	Rent-Facility & Grounds			823,987	823,987		823,987		823,987			34
35	Rent-Equipment & Vehicles			78,376	78,376		78,376		78,376			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,092,818	1,092,818		1,092,818	34,811	1,127,629			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		267,397	105,562	372,959		372,959		372,959			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,333	113,333		113,333		113,333			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		267,397	218,895	486,292		486,292		486,292			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,890,146	1,027,980	3,347,655	9,265,781		9,265,781	(7,006)	9,258,775			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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	42,155	30		9
10	Interest and Other Investment Income	(7,344)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,435)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(450)	20		20
21	Owner or Key-Man Insurance	(20,761)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(13,833)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(896)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,764)		\$	30

<b>BHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(22,851)		34
35	Other- Attach Schedule	18,609	19	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (4,242)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (7,006)		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	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BURGESS SQUARE HEALTHCARE CTR

ID# 0029199

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **BURGESS SQUARE HEALTHCARE CTR**# **0029199**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007****SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,435)	0	0	0	0	0	0	0	0	0	0	(1,435)	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,435)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,435)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(35,915)	0	0	0	0	0	0	0	0	0	(35,915)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	18,609	0	0	0	0	0	0	0	0	0	0	18,609	19
20	Fees, Subscriptions & Promotions	(15,379)	0	0	0	0	0	0	0	0	0	0	(15,379)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(20,761)	0	0	0	0	0	0	0	0	0	0	(20,761)	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	13,064	0	0	0	0	0	0	0	0	0	13,064	27
28	<b>TOTAL General Administration</b>	<b>(17,531)</b>	<b>(22,851)</b>	<b>0</b>	<b>(40,382)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(18,966)</b>	<b>(22,851)</b>	<b>0</b>	<b>(41,817)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR# 0029199

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	42,155	0	0	0	0	0	0	0	0	0	0	42,155	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,344)	0	0	0	0	0	0	0	0	0	0	(7,344)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>34,811</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>34,811</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>15,845</b>	<b>(22,851)</b>	<b>0</b>	<b>(7,006)</b>	<b>45</b>								

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACQUELINE MASON	70	N/A		UNITED CARE	OVANDO, MONTANA	MGMT CO
MONTY MILLER	30			MGMT PROF FOR HC	CLARENDON HILLS, IL	BKKP CONSLT

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$ 201,915	UNITED CARE		\$	\$ (201,915)	1
2	V							2
3	V							3
4	V	17 ADMINISTRATIVE		" "		166,000	166,000	4
5	V	27 EMPLOYEE BENEFITS		" "		13,064	13,064	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 201,915			\$ 179,064	\$ * (22,851)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	0	\$ *

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

Facility Name & ID Number **BURGESS SQUARE HEALTHCARE CTR** # **0029199** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

## 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	JACQUELINE MASON	PRESIDENT	ADMIN	70.00	N/A			SALARY	\$ 81,250	17-7	1
2	MONTY MILLER	VICE PRESIDENT	ADMIN	30.00	N/A			SALARY	84,750	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 166,000		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 HEALTHCARE CTR**

# **0029199**

Report Period Beginning:

**01/01/2007**

Ending: **2/31/2007**

**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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

**BURGESS SQUARE HEALTHCARE CTR**

# **0029199**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007**

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	TOWN CENTER BANK		X	LINE OF CREDIT	INTEREST			578,000			14,912	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$	\$ 578,000			\$ 14,912	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 578,000			\$ 14,912	15						

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

\* 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**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	<b>106,500</b>	<b>1</b>
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.)		\$	<b>112,757</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>6,257</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>115,000</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>121,257</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>93,444</b>	<b>8</b>
	2003	<b>96,085</b>	<b>9</b>
	2004	<b>101,841</b>	<b>10</b>
	2005	<b>104,181</b>	<b>11</b>
	2006	<b>112,757</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.**

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BURGESS SQUARE HEALTHCARE CTR COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0029199

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

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

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-15-107-044</u>	<u>NURSING HOME</u>	\$ <u>112,756.83</u>	\$ <u>112,756.83</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>112,756.83</u>	\$ <u>112,756.83</u>

**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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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 HEALTHCARE CTR

# 0029199

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 57,000 B. General Construction Type: Exterior BRICK Frame STEEL STRUCTURE Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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				\$	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	VARIOUS		1985	86,486		20			86,486
10	VARIOUS		1986	87,317		20			87,317
11	VARIOUS		1987	10,202	324	20		(324)	10,202
12	VARIOUS		1988	11,485	382	20	574	192	11,180
13	VARIOUS		1989	25,270	600	20	1,264	664	23,545
14	VARIOUS		1990	52,220	750	20	2,612	1,862	46,802
15	VARIOUS		1991	27,798	500	20	585	85	28,968
16	VARIOUS		1992	12,659	370	20	633	263	9,671
17	VARIOUS		1993	342,712	10,052	20	17,135	7,083	243,610
18	VARIOUS		1994	16,249	417	20	813	396	11,224
19	VARIOUS		1995	20,503	526	20	1,025	499	12,828
20	VARIOUS		1996	23,823	611	20	1,191	580	13,559
21	VARIOUS		1997	29,589	759	20	1,479	720	15,740
22	VARIOUS		1998	36,702	967	20	1,837	870	17,744
23	VARIOUS		1999	88,002	2,228	20	4,399	2,171	37,090
24	VARIOUS		2000	195,196	5,005	20	9,761	4,756	75,902
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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 HEALTHCARE CTR**# **0029199**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	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	ELEVATOR IMPROVEMENT	2001	\$ 2,150	\$ 55	20	\$ 108	\$ 53	\$ 755	37
38	HOT WATER TANK	2001	5,646	145	20	282	137	1,952	38
39	ROOF IMPROVEMENT	2001	11,275	289	20	564	275	3,854	39
40	DOORS	2001	1,595	41	20	80	39	540	40
41	ELECTRICAL WALL PAKS	2001	1,258	32	20	63	31	420	41
42	ELECTRICAL WORK	2001	1,795	46	20	90	44	570	42
43	CARPETS	2001	5,009		20	501	501	3,173	43
44	SIGNS	2001	3,000		20	300	300	1,900	44
45	HVAC UNIT	2001	11,500	295	20	575	280	3,594	45
46	HVAC UNIT	2001	11,500	295	20	575	280	3,546	46
47	SIGNS	2001	930		20	93	93	574	47
48	SIGNS	2001	2,526		20	253	253	1,559	48
49	PLUMBING	2001	11,314	290	20	566	276	3,442	49
50	CARPENTRY	2001	1,607	41	20	80	39	488	50
51	CALL STATION	2001	1,536		20	77	77	481	51
52	NETWORK CABLES	2001	987		20	49	49	315	52
53	TELEPHONE	2001	770		20	39	39	243	53
54	ELECTRIC RANGE	2001	1,036		20	52	52	316	54
55	CALL STATION	2001	568		20	28	28	197	55
56	TILE	2001	582		20	29	29	196	56
57	TILE	2001	1,187		20	59	59	399	57
58	TELEPHONE	2001	599		20	30	30	193	58
59	PLUMBING	2001	809		20	40	40	251	59
60	HEAT EXCHANGER	2001	1,400		20	70	70	438	60
61	TILE	2001	539		20	27	27	171	61
62	SECURITY SYSTEM	2001	1,072		20	54	54	337	62
63	HEAT EXCHANGER	2001	710		20	36	36	224	63
64	TIME CLOCK/LIGHTS AN	2001	1,395		20	70	70	432	64
65	BLOWER/IGNITOR	2001	652		20	33	33	200	65
66	COOLER	2001	1,226		20	61	61	372	66
67	EXHAUST	2002	925		20	93	93	526	67
68	GENERATOR	2002	2,018		20	202	202	1,144	68
69	PAINTING	2002	1,980		20	198	198	1,172	69
70	TOTAL (lines 4 thru 69)		\$ 1,157,309	\$ 25,020		\$ 48,685	\$ 23,665	\$ 765,842	70

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

Facility Name & ID Number **BURGESS SQUARE HEALTHCARE CTR**# **0029199**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,157,309	\$ 25,020		\$ 48,685	\$ 23,665	\$ 765,842	1
2	PAINTING	2002	700		20	70	70	408	2
3	SHELVING	2002	830		20	83	83	484	3
4	EXHAUST FAN	2002	1,525		20	153	153	904	4
5	HEAT EXCHANGER	2002	2,200		20	220	220	1,155	5
6	FREEZER	2002	608		20	61	61	350	6
7	COMPRESSOR	2002	618		20	62	62	372	7
8	VACUUM PUMP	2002	645		20	65	65	357	8
9	PLUMBING	2002	781		20	78	78	416	9
10	BATTERY	2002	567		20	57	57	313	10
11	CEILING TILES	2002	1,826		20	183	183	1,052	11
12	FIRE DOORS	2002	3,921		20	392	392	2,189	12
13	TILES	2002	1,132		20	113	113	660	13
14	PIPE	2002	550		20	55	55	307	14
15	COMPRESSOR	2002	1,483		20	148	148	827	15
16	PLUMBING	2002	629		20	63	63	367	16
17	TILE STRIP/WAX	2002	7,000		20	700	700	4,200	17
18	HVAC UNIT	2003	12,150		20	405	405	2,025	18
19	PIPING/PLUMBING	2003	5,250		20	241	241	1,205	19
20	SIDEWALK REMOVAL/REPAIR	2003	3,300		20	41	41	205	20
21	ELEVATOR REPAIR	2003	1,158		20	29	29	145	21
22	DOOR FRAME REPAIR	2003	679		20	28	28	140	22
23	FAN REPAIRS	2003	500		20	15	15	75	23
24	COMPRESSOR REPAIR	2003	1,065		20	40	40	200	24
25	COMPRESSOR REPAIR	2003	825		20	31	31	155	25
26	COMPRESSOR REPAIR	2003	591		20	15	15	75	26
27	CONDENSOR FAN MOTOR	2003	537		20	11	11	55	27
28	WATER HEATER	2004	5,400	139	39	139		478	28
29	NEW HEATING UNIT	2004	12,250	314	39	314		1,086	29
30	20 FT STORM PIPE	2004	4,500	115	39	115		398	30
31	FIRE EXTINGUISHER SYSTEM	2006	4,354	112	39	112		168	31
32	GAS VALVE	2006	705	18	39	18		27	32
33	NURSE CALL PROJECT	2006	35,983	923	39	923		1,384	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,271,571	\$ 26,641		\$ 53,665	\$ 27,024	\$ 788,024	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,271,571	\$ 26,641		\$ 53,665	\$ 27,024	\$ 788,024	1
2	DOOR SEALS	2006	4,778	122	39	122		178	2
3	COMPRESSOR/PARTS	2006	3,238	83	39	83		121	3
4	EXHAUST FAN/DUCT WORK	2006	1,800	46	39	46		68	4
5	FIRE DOOR	2006	823	21	39	21		31	5
6	CONCRETE REPLACEMENT	2007	27,425	914	39	914		914	6
7	FLOORING	2007	4,697	55	39	55		55	7
8	WALLCOVERING	2007	8,646	102	39	102		102	8
9	BLINDS, SHEARS, VALANCES	2007	8,183	96	39	96		96	9
10	LIGHT FIXTURES	2007	2,148	25	39	25		25	10
11	CAMERA & MONITOR INSTALLATION	2007	1,680	20	39	20		20	11
12	DESIGN/ARCHITECT FEES	2007	30,427	358	39	358		358	12
13	RENOVATION 2ND FL PHYSICAL THERAPY & COMMON A	2007	73,683	866	39	866		866	13
14	PLUMBING FIXTURES	2007	5,901	69	39	69		69	14
15	CABINETS & COUNTER TOPS	2007	27,000	317	39	317		317	15
16	BISTRO AREA RENOVATION	2007	4,604	54	39	54		54	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,476,604	\$ 29,789		\$ 56,813	\$ 27,024	\$ 791,298	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 378,344	\$ 16,097	\$ 37,528	\$ 21,431	10 YRS	\$ 314,759	71
72	Current Year Purchases	42,003	8,400	2,100	(6,300)	10 YRS	2,100	72
73	Fully Depreciated Assets	245,612					245,612	73
74								74
75	TOTALS	\$ 665,959	\$ 24,497	\$ 39,628	\$ 15,131		\$ 562,471	75

D. Vehicle Depreciation (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)	\$ 2,142,563	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,286	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,441	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 42,155	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,353,769	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: **CAMELOT HEALTHCARE CENTER**

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:		211		\$ 823,987			3
4	Additions							4
5								5
6								6
7	TOTAL		211		\$ 823,987			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: \$ **78,376** Description: **SEE SCHEDULE 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

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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)**

	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	39-3	hrs	\$		\$ 0	\$		\$	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs			37,850				37,850	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs			67,712				67,712	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 prescripts				215,234			215,234	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	RADIOLOGY, LAB, RENTAL, OTHER Other (specify):						52,163			52,163	13
14	<b>TOTAL</b>			\$		\$ 105,562	\$ 267,397		\$	372,959	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.

Facility Name & ID Number **BURGESS SQUARE HEALTHCARE CTR**

# **0029199**

Report Period Beginning: **01/01/2007**

Ending:

**12/31/2007**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2007**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 269,440	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,599,970		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	238,533		6
7	Other Prepaid Expenses	29,813		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,137,756	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,350,084		15
16	Equipment, at Historical Cost	688,380		16
17	Accumulated Depreciation (book methods)	(1,113,920)		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): <b>CONSTR IN PROGRESS</b>	16,103		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 940,647	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,078,403	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 467,519	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	628,000		29
30	Accrued Salaries Payable	96,625		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,094		31
32	Accrued Real Estate Taxes(Sch.IX-B)	115,000		32
33	Accrued Interest Payable	3,057		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,326,295	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,326,295	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,752,108	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,078,403	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,951,705</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,951,705</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>403</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(200,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(199,597)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,752,108</b>	<b>24</b> *

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

**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

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 9,117,153	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,117,153	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	144,113	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 144,113	8
	<b>C. Other Operating Revenue</b>		
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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	7,344	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,344	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING COMMISSIONS-NET</b>	2,331	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,331	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,270,941	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,719,607	31
32	Health Care	4,024,466	32
33	General Administration	1,942,598	33
	<b>B. Capital Expense</b>		
34	Ownership	1,092,818	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	372,959	35
36	Provider Participation Fee	113,333	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,265,781	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	5,160	41
42	<b>Income Taxes</b>	(4,757)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 403	43

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

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

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

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

Facility Name & ID Number **BURGESS SQUARE HEALTHCARE CTR**

# **0029199**

Report Period Beginning: **01/01/2007**

Ending: **12/31/2007**

**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	1,872	2,240	\$ 74,181	\$ 33.12	1
2	Assistant Director of Nursing	1,984	2,184	72,917	33.39	2
3	Registered Nurses	13,355	14,788	460,361	31.13	3
4	Licensed Practical Nurses	27,206	30,158	783,199	25.97	4
5	CNAs & Orderlies	110,139	115,880	1,224,721	10.57	5
6	CNA Trainees					6
7	Licensed Therapist	5,525	6,116	155,697	25.46	7
8	Rehab/Therapy Aides	2,904	3,253	49,238	15.14	8
9	Activity Director	1,720	2,024	41,462	20.49	9
10	Activity Assistants	11,166	12,137	117,137	9.65	10
11	Social Service Workers	15,185	17,275	275,016	15.92	11
12	Dietician					12
13	Food Service Supervisor	4,158	4,758	97,979	20.59	13
14	Head Cook	3,296	3,726	43,680	11.72	14
15	Cook Helpers/Assistants	27,909	29,819	245,634	8.24	15
16	Dishwashers					16
17	Maintenance Workers	6,288	7,156	95,539	13.35	17
18	Housekeepers	36,447	39,686	372,362	9.38	18
19	Laundry	8,849	10,079	91,352	9.06	19
20	Administrator	2,104	2,160	108,655	50.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,475	10,772	252,683	23.46	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	3,142	3,358	37,313	11.11	31
32	Other Health Care(specify)	8,497	9,521	291,020	30.57	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	301,221	327,090	\$ 4,890,146 *	\$ 14.95	34

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

\*\* See instructions.

**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	M	\$ 13,138	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	4,184	10-3	37
38	Nurse Consultant	T	15,000	10-3	38
39	Pharmacist Consultant	H	1,889	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,476	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 45,687		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	130	\$ 6,813	10-3	50
51	Licensed Practical Nurses	4,981	203,469	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	5,111	\$ 210,282		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
JO ANNE FISHER	ADMINISTRATOR		\$ 108,655	Workers' Compensation Insurance	\$ 125,707	IDPH License Fee	\$ 995	
			0	Unemployment Compensation Insurance	54,887	Advertising: Employee Recruitment	40,738	
				FICA Taxes	373,140	Health Care Worker Background Check	7,014	
				Employee Health Insurance	363,360	(Indicate # of checks performed <u>438</u> )		
				Employee Meals		Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	650	
				EMPLOYEE BENEFITS - OTHER	43,859	MARKETING/ADV/PROMO	14,729	
						LICENSES/DUES/SUBSCRIPTIONS	3,820	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 108,655			MGMT CO ALLOC		
(List each licensed administrator separately.)						TRUST/FRANCHISE/CONTRIB/ETC	(650)	
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE	20,761	Less: Public Relations Expense	(0)	
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21	(20,761)	Non-allowable advertising	(13,833)	
MANAGEMENT FEE			\$ 201,915			Yellow page advertising	(896)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 960,953	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 52,567	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 201,915	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
KRUPNICK BOKOR KAGDA	ACCOUNTING		\$ 27,750				In-State Travel	0
FROST RUTTENBERG	ACCOUNTING		2,459					
STONE MCGUIRE	LEGAL		11,295				Seminar Expense	0
DUANE MORRIS	LEGAL		93					
WILDMAN,HARROLD	LEGAL		814				Entertainment Expense	( )
ADP	RETIREMENT PLAN SVC		770				(agree to Sch. V, line 24, col. 8)	
RICHARD PEELO	MEDICARE CONSLT		6,000					
ACCUMED	DATA PROCESSING		6,840					
MUTUAL OF OMAHA	DATA PROCESSING		297					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 56,318	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number **BURGESS SQUARE HEALTHCARE CTR**# **0029199**Report Period Beginning: **01/01/2007**Ending: **12/31/2007****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? NO  
If YES, give association name and amount. \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,443 Line 10-2
- (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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 113,333  
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? N/A Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees