

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0026765

Facility Name: Burgin Manor of Olney, Inc.

Address: 900 East Scott Street Olney 62450
 Number City Zip Code

County: Richland

Telephone Number: (618) - 395 - 2150 Fax # (618) - 392 - 2150

HFS ID Number: _____

Date of Initial License for Current Owners: 04/20/82

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Ken Marx **Telephone Number:** (314) - 231- 5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2006 to 12/31/2006 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) _____	(Firm Name & Address) _____
	(Telephone) () _____	Fax # () _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number Burgin Manor of Olney, Inc.# 0026765 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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	<u>156</u>	Skilled (SNF)	<u>156</u>	<u>56,940</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>156</u>	TOTALS	<u>156</u>	<u>56,940</u>	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	<u>28,646</u>	<u>19,191</u>	<u>4,683</u>	<u>52,520</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,646</u>	<u>19,191</u>	<u>4,683</u>	<u>52,520</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.24%

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)

NoneF. 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 04/20/1982

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/20/1982 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 156 and days of care provided 4,683Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	301,789	25,658	11,695	339,142		339,142		339,142		1
2	Food Purchase		283,866		283,866		283,866	(4,198)	279,668		2
3	Housekeeping	126,404	30,277		156,681		156,681		156,681		3
4	Laundry	96,077	9,176	9,672	114,925		114,925		114,925		4
5	Heat and Other Utilities			138,160	138,160		138,160		138,160		5
6	Maintenance	67,505	13,861	68,460	149,826		149,826	85	149,911		6
7	Other (specify):*										7
8	TOTAL General Services	591,775	362,838	227,987	1,182,600		1,182,600	(4,113)	1,178,487		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,144,493	151,376	162,472	2,458,341		2,458,341		2,458,341		10
10a	Therapy	39,348	1,541	447,798	488,687		488,687		488,687		10a
11	Activities										11
12	Social Services	138,198	4,604	7,896	150,698		150,698		150,698		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,322,039	157,521	625,366	3,104,926		3,104,926		3,104,926		16
	C. General Administration										
17	Administrative	101,625		237,853	339,478		339,478	(16,322)	323,156		17
18	Directors Fees										18
19	Professional Services			21,462	21,462		21,462		21,462		19
20	Dues, Fees, Subscriptions & Promotions			15,323	15,323		15,323	(749)	14,574		20
21	Clerical & General Office Expenses	92,877	15,847	38,316	147,040		147,040	5,306	152,346		21
22	Employee Benefits & Payroll Taxes			666,647	666,647		666,647		666,647		22
23	Inservice Training & Education			295	295		295		295		23
24	Travel and Seminar			3,058	3,058		3,058		3,058		24
25	Other Admin. Staff Transportation			17,600	17,600		17,600		17,600		25
26	Insurance-Prop.Liab.Malpractice			112,691	112,691		112,691		112,691		26
27	Other (specify):*										27
28	TOTAL General Administration	194,502	15,847	1,113,245	1,323,594		1,323,594	(11,765)	1,311,829		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,108,316	536,206	1,966,598	5,611,120		5,611,120	(15,878)	5,595,242		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Burgin Manor of Olney, Inc. #0026765 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			108,297	108,297	108,297	407	108,704			30
31	Amortization of Pre-Op. & Org.			3,345	3,345	3,345		3,345			31
32	Interest			130,803	130,803	130,803	(6,864)	123,939			32
33	Real Estate Taxes			84,612	84,612	84,612		84,612			33
34	Rent-Facility & Grounds						11,150	11,150			34
35	Rent-Equipment & Vehicles			30,936	30,936	30,936	1,463	32,399			35
36	Other (specify):*										36
37	TOTAL Ownership			357,993	357,993	357,993	6,156	364,149			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		19,336		19,336	19,336		19,336			39
40	Barber and Beauty Shops			29,038	29,038	29,038		29,038			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			85,410	85,410	85,410		85,410			42
43	Other (specify):* Sales Tax			100,611	100,611	100,611	(121,926)	(21,315)			43
44	TOTAL Special Cost Centers		19,336	215,059	234,395	234,395	(121,926)	112,469			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,108,316	555,542	2,539,650	6,203,508	6,203,508	(131,648)	6,071,860			45

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

Facility Name & ID Number Burgin Manor of Olney, Inc.

0026765

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(3,709)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17,243)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(23,443)	43		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(33,942)	43		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	(70,095)	various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (148,432)		\$	30

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	
		Amount	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)	16,784	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 16,784		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (131,648)		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	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Burgin Manor of Olney, Inc.

ID# 0026765

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	lobbying expense	\$ (749)	20	1
2	offset interest income	(19,385)	32	2
3	offset vending income	(6,737)	43	3
4	offset telephone income	(2,174)	21	4
5	newscoop	(5,076)	43	5
6	transfer insurance	(9,364)	43	6
7	public relations	(12,382)	43	7
8	golden friendship	(314)	43	8
9	resident/ family realtions	(3,754)	43	9
10	corporate taxes	(5,962)	43	10
11	employee meals income	(4,198)	2	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	(70,095)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burgin Manor of Olney, Inc.# 0026765

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,198)	0	0	0	0	0	0	0	0	0	0	(4,198)	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	85	0	0	0	0	0	0	0	0	0	85	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,198)	85	0	(4,113)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(16,322)	0	0	0	0	0	0	0	0	0	(16,322)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(749)	0	0	0	0	0	0	0	0	0	0	(749)	20
21	Clerical & General Office Expenses	(2,174)	7,480	0	0	0	0	0	0	0	0	0	5,306	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	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	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,923)	(8,842)	0	(11,765)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,121)	(8,757)	0	(15,878)	29								

STATE OF ILLINOIS

Facility Name & ID Number Burgin Manor of Olney, Inc.

0026765

Report Period Beginning:

1/1/2006 Ending:

Summary B

12/31/2006

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	0	407	0	0	0	0	0	0	0	0	0	407	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,385)	12,521	0	0	0	0	0	0	0	0	0	(6,864)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	11,150	0	0	0	0	0	0	0	0	0	11,150	34
35	Rent-Equipment & Vehicles	0	1,463	0	0	0	0	0	0	0	0	0	1,463	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(19,385)	25,541	0	6,156	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(121,926)	0	0	0	0	0	0	0	0	0	0	(121,926)	43
44	TOTAL Special Cost Centers	(121,926)	0	0	0	0	0	0	0	0	0	0	(121,926)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(148,432)	16,784	0	(131,648)	45								

Facility Name & ID Number Burgin Manor of Olney, Inc.# 0026765

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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
<u>Jerold Axelbaum</u>	<u>30.56</u>			<u>Burgin Health</u>	<u>Univeristy City</u>	<u>Management Co.</u>
<u>Shirley Axelbaum</u>	<u>30.56</u>			<u>Management Inc.</u>		
<u>Steven Axelbaum</u>	<u>1.01</u>					
<u>Bruce Axelbaum</u>	<u>18.43</u>					
<u>Richard Axelbaum</u>	<u>9.72</u>					
<u>David Axelbaum</u>	<u>9.72</u>					

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	<u>17</u> <u>Management Fees</u>	\$ <u>237,853</u>	<u>Burgin Health Management Inc.</u>		\$ <u>211,531</u>	\$ <u>(26,322)</u>	1
2	V	<u>17</u> <u>Officer Salaries</u>		<u>Burgin Health Management Inc.</u>		<u>10,000</u>	<u>10,000</u>	2
3	V	<u>21</u> <u>Taxes and Licenses</u>		<u>Burgin Health Management Inc.</u>		<u>511</u>	<u>511</u>	3
4	V	<u>21</u> <u>Clerical Expenses</u>		<u>Burgin Health Management Inc.</u>		<u>6,609</u>	<u>6,609</u>	4
5	V	<u>35</u> <u>Equipment</u>		<u>Burgin Health Management Inc.</u>		<u>1,463</u>	<u>1,463</u>	5
6	V	<u>30</u> <u>Depreciation</u>		<u>Burgin Health Management Inc.</u>		<u>407</u>	<u>407</u>	6
7	V	<u>32</u> <u>Interest</u>		<u>Burgin Health Management Inc.</u>		<u>12,521</u>	<u>12,521</u>	7
8	V	<u>34</u> <u>Rent</u>		<u>Burgin Health Management Inc.</u>		<u>11,150</u>	<u>11,150</u>	8
9	V	<u>21</u> <u>Miscellaneous</u>		<u>Burgin Health Management Inc.</u>		<u>360</u>	<u>360</u>	9
10	V	<u>6</u> <u>Plant Operation & Maintenance</u>		<u>Burgin Health Management Inc.</u>		<u>85</u>	<u>85</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>237,853</u>			\$ <u>254,637</u>	\$ * <u>16,784</u>	14

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

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Burgin Manor of Olney, Inc.

0026765

Report Period Beginning:

1/1/2006

Ending: 2/31/2006

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 Burgin Health Management
 Street Address 8220 Delmar
 City / State / Zip Code University City, MO
 Phone Number (314) - 692 - 0777
 Fax Number (314) - 392 - 0406

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	17	Management Fees	Direct Costs	1	\$ 211,531	\$	1	\$ 211,531	1
2	17	Officer Salaries	Direct Costs	1	10,000		1	10,000	2
3	21	Taxes and Licenses	Direct Costs	1	511		1	511	3
4	21	Clerical Expenses	Direct Costs	1	6,609		1	6,609	4
5	35	Equipment	Direct Costs	1	1,463		1	1,463	5
6	30	Depreciation	Direct Costs	1	407		1	407	6
7	32	Interest	Direct Costs	1	12,521		1	12,521	7
8	34	Rent	Direct Costs	1	11,150		1	11,150	8
9	21	Miscellaneous	Direct Costs	1	360		1	360	9
10	6	Plant Operation & Maint	Direct Costs	1	85		1	85	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				\$ 254,637	\$		\$ 254,637	25

Facility Name & ID Number

Burgin Manor of Olney, Inc.

0026765

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	U.S. Bank		X	Mortgage	\$3,100 + Int	10/4/02	\$ 2,245,000	\$ 2,056,127	10/4/07	libor+2.5%	\$ 98,700	1
2	Toyota Financial Services		X	2004 Camry	5yrs @ 5.074	3/17/04	21,595	10,032	3/17/09	5.0740	627	2
3	Lexus Financial Services		X	2002 Lexus	5yrs @ 3.9	5/3/05	26,617		5/3/10	3.9000	343	3
4												4
5												5
Working Capital												
6	U.S. Bank		X	Operating	Interest	10/4/02	494,925	350,000	10/4/07	libor+2.5%	26,868	6
7	Various		X	Various	Various	Various			Various	Various	4,169	7
8												8
9	TOTAL Facility Related						\$ 2,788,137	\$ 2,416,159			\$ 130,707	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,788,137	\$ 2,416,159			\$ 130,707	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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 2005 report.	\$	75,786	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.)	\$	80,199	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,413	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	80,199	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.	\$	84,612	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	77,133	8
	2002	77,254	9
	2003	73,238	10
	2004	73,238	11
	2005	75,786	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burgin Manor of Olney, Inc. COUNTY Richland

FACILITY IDPH LICENSE NUMBER 0026765

CONTACT PERSON REGARDING THIS REPORT Ms. Sue Burgin

TELEPHONE (618) - 395 - 1000 FAX #: (618) - 392 - 2150

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>1-06-35-350-001</u>	<u>See Attached</u>	\$ <u>49,117.14</u>	\$ <u>49,117.14</u>
2. <u>1-06-35-350-002</u>	<u>See Attached</u>	\$ <u>31,082.08</u>	\$ <u>31,082.08</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>80,199.22</u>	\$ <u>80,199.22</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Burgin Manor of Olney, Inc.# 0026765 Report Period Beginning:1/1/2006 Ending:12/31/2006**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 41,617 B. General Construction Type: Exterior Brick Frame Wood Number of Stories OneC. 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/AF. 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	<u>Resident Care</u>	<u>234,725</u>		<u>\$ 75,000</u>	1
2					2
3	TOTALS	234,725		\$ 75,000	3

Facility Name & ID Number **Burgin Manor of Olney, Inc.**# **0026765**

Report Period Beginning:

1/1/2006

Ending:

12/31/2006**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1982	1982	\$ 1,510,000	\$	15	\$	\$	\$ 1,510,000	4
5			1996	1996	826,743	21,199	39	21,199		225,151	5
6											6
7											7
8											8
	Improvement Type**										
9	Aspen Lighting			1997	739		07			739	9
10	Fire Alarm			1997	1,316		07			1,316	10
11	Beds			1997	30,726		07			30,726	11
12	Flooring and Carpet			1994	3,946		07			3,946	12
13	Aspen Courtyard			1994	9,539	568	15	568		8,047	13
14	Fence-Aspen			1994	1,079	63	15	63		920	14
15	Windows/Doors			1994	19,291	495	39	495		6,163	15
16	Roof-Ambulance Entrance			1994	2,388	61	39	61		753	16
17	1989 Additions			1989	10,163		10			10,163	17
18	1990 Additions			1990	12,277		10			12,277	18
19	1991 Building Improvement			1991	28,943	919	31	919		14,395	19
20	Ceiling Tile			1992	3,542	112	31	112		1,597	20
21	Doors			1993	1,928	49	39	49		657	21
22	Tile Flooring			1993	14,085	447	31	447		6,130	22
23	Sprinkler System			1993	800	25	31	25		350	23
24	Hand Rails			1993	205	5	39	5		70	24
25	Glass Doors			1993	1,456	37	39	37		499	25
26	Nurses Station			1993	1,222	39	31	39		532	26
27	Paint and Wallpaper			1993	26,202	655	40	655		10,127	27
28	Hall Lights			1992	4,383	139	31	139		1,965	28
29	1986 Additions			1986	24,917		19			24,917	29
30	Remodel PT Room			1994	440	11	39	11		126	30
31	Flooring PT Room			1995	1,328	34	39	34		380	31
32	Floor Tile			1995	732	19	39	19		213	32
33	Carpet			1995	786	20	39	20		228	33
34	Architect Fees			1996	6,263		07			6,263	34
35	Cabinets/Countertops			1996	10,115		07			10,115	35
36											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 Burgin Manor of Olney, Inc.# 0026765

Report Period Beginning:

1/1/2006

Ending:

12/31/2006**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	<u>Therapy Tub</u>	1996	\$ 13,348	\$	07	\$	\$	\$ 13,348	37
38	<u>Flooring\Carpet\Tile</u>	1996	24,840		07			24,840	38
39	<u>Awnings</u>	1996	3,595	209	15	209		2,656	39
40	<u>Sidewalk repairs</u>	1996	910	53	15	53		672	40
41	<u>Air Conditioner</u>	1996	1,699		07			1,699	41
42	<u>Outdoor Lighting</u>	1996	161		07			161	42
43	<u>Air Conditioner System</u>	1996	25,780		07			25,780	43
44	<u>Room Signs</u>	1996	893		07			893	44
45	<u>Soffit</u>	1998	16,899	433	39	433		3,665	45
46	<u>Lights CTR Hall West</u>	1998	1,085	28	39	28		237	46
47	<u>Lights CTR Hall East</u>	1998	701	18	39	18		158	47
48	<u>Lights E Hall West</u>	1998	1,670	43	39	43		366	48
49	<u>Carpet #170</u>	1997	498		07			498	49
50	<u>Door closers</u>	1998	1,062		07			1,062	50
51	<u>Lighting Improvements</u>	1998	9,850	253	39	253		2,200	51
52	<u>Carpet for employee break room</u>	1999	296	13	07	13		296	52
53	<u>Carpet for Aspen dining room</u>	1999	888	40	07	40		888	53
54	<u>West Building Nurse Station Drop Ceiling</u>	1999	531	14	39	14		105	54
55	<u>Aspen Drop Ceiling</u>	1999	1,221	31	39	31		240	55
56	<u>Electrical Panel - West Building</u>	2000	1,164	104	07	104		1,112	56
57	<u>3 CEILING FANS</u>	2001	1,359	49	27	49		294	57
58	<u>ARCHITECTURAL SERVICES</u>	2001	12,131	441	27	441		2,518	58
59	<u>DRYWALLING</u>	2001	919	33	27	33		194	59
60	<u>2 BDR CONVERTED TO DINING ROOM IN ASPEN</u>	2001	1,103	40	27	40		216	60
61	<u>ROOM 175 BATHROOM FLOORING</u>	2002	255	9	27	9		38	61
62	<u>ROOF ON WEST BUILDING</u>	2003	47,312	1,720	27	1,720		5,950	62
63	<u>TILE FLOORING FOR EAST DINING ROOM & WEST LOBBY</u>	2003	2,236	81	27	81		322	63
64	<u>ASPEN LIGHTING</u>	2003	1,219		07			1,219	64
65	<u>Roof on East Building</u>	2004	36,916	1,342	27	1,342		3,300	65
66	<u>Generator</u>	2004	25,671	934	27	934		2,061	66
67	<u>New Handrails in East Building</u>	2004	3,252	118	27	118		281	67
68	<u>Exterior Door for Laundry</u>	2004	950	35	27	35		82	68
69	<u>Medicare Wing Room Lights</u>	2004	1,822		7			1,822	69
70	TOTAL (lines 4 thru 69)		\$ 2,797,790	\$ 30,942		\$ 30,942	\$	\$ 1,987,939	70

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

Facility Name & ID Number Burgin Manor of Olney, Inc.# 0026765

Report Period Beginning:

1/1/2006

Ending:

12/31/2006**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	Totals from Page 12A, Carried Forward		\$ 2,797,790	\$ 30,942		\$ 30,942	\$	\$ 1,987,939	1
2	Concrete Floor for Laundry	2005	1,119	41	27	41		56	2
3	AIR CONDITIONER & HEATER (DELTA WING)	2006	27,340	704	27	704		704	3
4	DUCT WORK FOR AIR CONDITIONER	2006	552	16	27	16		16	4
5	Driveway	1997	8,461	491	15	491		5,759	5
6	1991 Land Improvement	1991	622	18	15	18		622	6
7	Landscaping	1992	1,112	66	15	66		1,079	7
8	Asphalt Repairs	1995	455		10			455	8
9	Courtyard Trees	1996	821		07			821	9
10	Backhoe Parking Lot	1996	135		07			135	10
11	Truck Labor	1996	70		07			70	11
12	Concrete Pads/Mix	1996	330		07			330	12
13	Concrete pads/Screws	1996	177		07			177	13
14	Landscaping	1998	1,292	75	15	75		805	14
15	Fencing	1998	15,209	883	15	883		9,469	15
16	Parking Lot	1998	23,912	1,388	15	1,388		14,887	16
17	LANDSCAPING	1997	2,287	133	15	133		1,557	17
18	Sidewalk	1999	10,278	611	15	611		5,696	18
19	Driveway	1999	19,536	1,164	15	1,164		10,808	19
20	Concrete Pad for Dumpster Site	2000	906	53	15	53		451	20
21	NEW PARKING LOT FOR EAST BLDG	2006	11,300	565	15	565		565	21
22	116 Lamps	2000	5,502	491	7	491		5,257	22
23	Electrical Fixtures	2000	3,761	336	7	336		3,593	23
24	Alarm System	2000	10,261	915	7	915		9,803	24
25	70 Overbed tables	2000	5,670	506	7	506		5,417	25
26	73 4-Drawer Cabinets	2000	19,256	1,718	7	1,718		18,397	26
27	Drapes, Valances, & Bedspreads	2000	23,184	2,069	7	2,069		22,150	27
28	Sidewalks	2000	14,236	840	15	840		7,090	28
29	65 Chairs	2000	11,939	1,065	7	1,065		11,406	29
30	Remodeling	2000	8,255	736	7	736		7,886	30
31	Floor tiling and Wallpapering	2000	3,799	339	7	339		3,629	31
32					5				32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,029,568	\$ 46,165		\$ 46,165	\$	\$ 2,137,029	34

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

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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	\$ 506,737	\$ 10,264	\$ 10,264	\$		\$ 485,225	71
72	Current Year Purchases	48,291	37,808	37,808			48,292	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 555,028	\$ 48,072	\$ 48,072	\$		\$ 533,517	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	Residential Care	92 Ford Ranger	1996	\$ 3,780	\$	\$	\$	5	\$ 3,780	76
77	Facility Use	00 Ford 13 Passanger Van	2000	42,810	1,775	1,775			18,010	77
78	Facility Use	98 Toyota Avalon	2001	17,000	1,775	1,775			16,235	78
79	Facility Use	See Schedule F below	various	57,395	10,510	10,510			21,220	79
80	TOTALS			\$ 120,985	\$ 14,060	\$ 14,060	\$		\$ 59,245	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)		\$ 3,780,581	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 108,297	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 108,297	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,729,791	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	04 Toyota Camry acquired in 2004	\$ 24,399	\$ 2,850	\$ 18,260	86
87	Tade in 02 lexius for 03 audi	32,996	7,660	2,960	87
88					88
89					89
90					90
91	TOTALS	\$ 57,395	\$ 10,510	\$ 21,220	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: _____

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 28,111 Description: IVAC Pumps \$2531, Oxygen Concentrators \$11145, Specialty Bed \$13834, Pulse oxygen \$600

(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.

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>
--	---	--

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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Burgin Manor of Olney, Inc.# 0026765 Report Period Beginning:

1/1/2006 Ending: 12/31/2006

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		hrs	\$	2,549	\$ 157,550	\$ 631	2,549	\$ 158,181	1
2	Licensed Speech and Language Development Therapist		hrs		844	64,012		844	64,012	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,543	226,236	911	3,543	227,147	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	6,936	\$ 447,798	\$ 1,542	6,936	\$ 449,340	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.

STATE OF ILLINOIS

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Facility Name & ID Number Burgin Manor of Olney, Inc.# 0026765Report Period Beginning: 1/1/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 303,165	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	924,867		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,743		6
7	Other Prepaid Expenses	70,850		7
8	Accounts Receivable (owners or related parties)	506,171		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,814,796	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,000		13
14	Buildings, at Historical Cost	3,029,568		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	676,013		16
17	Accumulated Depreciation (book methods)	(2,729,791)		17
18	Deferred Charges	256,305		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,307,095	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,121,891	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 141,726	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,096,295		29
30	Accrued Salaries Payable	154,288		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,199		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Liabilities	61,622		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,534,130	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	352,159		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 352,159	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,886,289	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 235,602	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,121,891	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (234,710)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (234,710)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	470,312	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 470,312	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)	\$ 235,602	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Burgin Manor of Olney, Inc.# 0026765Report Period Beginning: 1/1/2006Ending: 12/31/2006**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,427,314	1
2	Discounts and Allowances for all Levels	(669,291)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,758,023	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	507,094	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 507,094	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	32,282	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	4,316	15
16	Rental of Facility Space		16
17	Sale of Drugs	134,361	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	165,713	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 336,672	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	19,384	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,384	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Miscellaneous Revenue	52,647	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 52,647	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,673,820	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,182,600	31
32	Health Care	3,104,926	32
33	General Administration	1,323,594	33
B. Capital Expense			
34	Ownership	357,993	34
C. Ancillary Expense			
35	Special Cost Centers	148,985	35
36	Provider Participation Fee	85,410	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,203,508	40
41	Income before Income Taxes (line 30 minus line 40)**	470,312	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 470,312	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 Burgin Manor of Olney, Inc.

0026765

Report Period Beginning: 1/1/2006

Ending:

12/31/2006

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	2,024	2,291	\$ 61,841	\$ 26.99	1
2	Assistant Director of Nursing	1,998	2,223	44,567	20.05	2
3	Registered Nurses	34,064	36,378	679,886	18.69	3
4	Licensed Practical Nurses	19,957	21,152	323,235	15.28	4
5	CNAs & Orderlies	108,423	112,711	1,034,964	9.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,033	3,360	39,348	11.71	8
9	Activity Director	2,040	2,086	25,499	12.22	9
10	Activity Assistants	12,225	12,470	94,221	7.56	10
11	Social Service Workers	1,925	1,972	18,478	9.37	11
12	Dietician					12
13	Food Service Supervisor	2,070	2,150	35,790	16.65	13
14	Head Cook	13,211	13,595	110,681	8.14	14
15	Cook Helpers/Assistants	21,189	21,652	151,685	7.01	15
16	Dishwashers					16
17	Maintenance Workers	5,431	5,631	67,505	11.99	17
18	Housekeepers	15,201	15,963	126,404	7.92	18
19	Laundry	11,803	12,059	96,077	7.97	19
20	Administrator	2,086	2,286	71,869	31.44	20
21	Assistant Administrator	1,521	1,669	29,756	17.83	21
22	Other Administrative					22
23	Office Manager	1,915	2,126	42,527	20.01	23
24	Clerical	3,765	3,975	50,350	12.67	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	263,879	275,747	\$ 3,104,684 *	\$ 11.26	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	204	\$ 10,189	line1 (3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	216	9,705	Line 10a (3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	60	2,715	Line 10a (3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	99	4,466	Line 10a (3)	43
44	Activity Consultant	24	1,661	line 11 (3)	44
45	Social Service Consultant	24	1,661	line 12 (3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	627	\$ 30,397		49

C. CONTRACT NURSES

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

Facility Name & ID Number Burgin Manor of Olney, Inc.

0026765

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Shirley Axelbaum		30.56	\$	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
Sue Burgin			71,869	Unemployment Compensation Insurance		Advertising: Employee Recruitment	719	
Una Tarpley			29,756	FICA Taxes		Health Care Worker Background Check	693	
				Employee Health Insurance	162,316	(Indicate # of checks performed <u>65</u>)		
				Employee Meals		Other/IL Health Care Assn Dues	9,970	
				Illinois Municipal Retirement Fund (IMRF)*		Various Books and Subscriptions	1,698	
				Employee Morale	9,123	Liscnse Fees	1,990	
				Other Employee Benefits	495,208	Quality Assurance	253	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 101,625					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees (eliminated in column 7)			\$ 237,853				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 237,853				Seminar Expense	3,058
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 20, col. 8)	
Vendor/Payee	Type	Amount						
Rosenblum, Goldenhirsch & Zaft	Legal	\$ 1,170						
Tom Weber	Legal	330						
Cunningham Accounting Svc	Accounting	8,062						
Stone Carlie & Co	Accounting	5,700						
BKD LLP	Accounting	6,200						
TOTAL (agree to Schedule V, line 19, column 3)				\$				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 21,462					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Burgin Manor of Olney, Inc.**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA 8611
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,994 Line
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 85,410
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 11,817
- c. What percent of all travel expense relates to transportation of nurses and patients?
- 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? 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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A 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 \$2500, 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.