

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 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:** 371116643001

**Date of Initial License for Current Owners:** 04/20/1982

**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
<b>IRS Exemption Code</b> _____	<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 1/1/2007 to 12/31/2007 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Ken Marx</u> <u>Partner</u>	
	(Firm Name & Address) <u>BKD, LLP</u> <u>501, N. Broadway, STE 600, St. Louis, MO 63021</u>	
	(Telephone) <u>314-231-5544</u> Fax # <u>314-231-9731</u>	

**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: 1/1/2007 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	<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>29,429</u>	<u>19,178</u>	<u>4,466</u>	<u>53,073</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>29,429</u>	<u>19,178</u>	<u>4,466</u>	<u>53,073</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.21%

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 &amp; 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 4/20/1982

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

YES  Date 4/20/1982 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 4,466Medicare 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 Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 1/1/2007 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	321,547	26,512	11,766	359,825		359,825		359,825		1
2	Food Purchase		292,523		292,523		292,523	(4,512)	288,011		2
3	Housekeeping	148,017	31,535		179,552		179,552		179,552		3
4	Laundry	100,962	11,910	11,164	124,036		124,036		124,036		4
5	Heat and Other Utilities			160,689	160,689		160,689		160,689		5
6	Maintenance	69,792	13,520	94,347	177,659		177,659	752	178,411		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>640,318</b>	<b>376,000</b>	<b>277,966</b>	<b>1,294,284</b>		<b>1,294,284</b>	<b>(3,760)</b>	<b>1,290,524</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,310,067	165,871	177,412	2,653,350		2,653,350		2,653,350		10
10a	Therapy	39,277	1,970	459,341	500,588		500,588		500,588		10a
11	Activities										11
12	Social Services	158,478	5,230	8,490	172,198		172,198		172,198		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,507,822</b>	<b>173,071</b>	<b>652,443</b>	<b>3,333,336</b>		<b>3,333,336</b>		<b>3,333,336</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	105,255		251,886	357,141		357,141	(23,863)	333,278		17
18	Directors Fees										18
19	Professional Services			26,207	26,207		26,207		26,207		19
20	Dues, Fees, Subscriptions & Promotions			13,306	13,306		13,306	(562)	12,744		20
21	Clerical & General Office Expenses	94,897	15,551	42,595	153,043		153,043	3,983	157,026		21
22	Employee Benefits & Payroll Taxes			729,039	729,039		729,039		729,039		22
23	Inservice Training & Education			182	182		182		182		23
24	Travel and Seminar			1,853	1,853		1,853		1,853		24
25	Other Admin. Staff Transportation			18,335	18,335		18,335		18,335		25
26	Insurance-Prop.Liab.Malpractice			108,414	108,414		108,414		108,414		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>200,152</b>	<b>15,551</b>	<b>1,191,817</b>	<b>1,407,520</b>		<b>1,407,520</b>	<b>(20,442)</b>	<b>1,387,078</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,348,292</b>	<b>564,622</b>	<b>2,122,226</b>	<b>6,035,140</b>		<b>6,035,140</b>	<b>(24,202)</b>	<b>6,010,938</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.

Facility Name & ID Number Burgin Manor of Olney, Inc. #0026765 Report Period Beginning: 1/1/2007 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			74,088	74,088	74,088	2,071	76,159			30
31	Amortization of Pre-Op. & Org.			2,508	2,508	2,508		2,508			31
32	Interest			143,524	143,524	143,524	(4,385)	139,139			32
33	Real Estate Taxes			80,464	80,464	80,464		80,464			33
34	Rent-Facility & Grounds						10,450	10,450			34
35	Rent-Equipment & Vehicles			23,961	23,961	23,961		23,961			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			324,545	324,545	324,545	8,136	332,681			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		23,164		23,164	23,164		23,164			39
40	Barber and Beauty Shops			24,767	24,767	24,767		24,767			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			85,410	85,410	85,410		85,410			42
43	Other (specify):* <b>Nonallowable</b>			102,463	102,463	102,463	(130,505)	(28,042)			43
44	<b>TOTAL Special Cost Centers</b>		23,164	212,640	235,804	235,804	(130,505)	105,299			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,348,292	587,786	2,659,411	6,595,489	6,595,489	(146,571)	6,448,918			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: 1/1/2007

Ending: 12/31/2007

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,846)	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	(19,158)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20,508)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(29,090)	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	(36,444)	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	(50,494)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (159,540)		\$	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)	12,969	Sch. VII	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 12,969		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (146,571)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY					
48		49	50	51	52

Burgin Manor of Olney, Inc.

ID# 0026765

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Newscoop	\$ (5,521)	43	1
2	Transfer Insurance	(13,152)	43	2
3	Public Relations	(10,853)	43	3
4	Golden Friendship	(262)	43	4
5	Resident / Family Relations	(3,427)	43	5
6				6
7	Vending	(7,281)	43	7
8	Corporate Taxes	(41)	43	8
9	Other - Misc.	(80)	43	9
10	Lobbying Expense	(749)	20	10
11				11
12	Offset Telephone Income	(2,741)	21	12
13	Employee meal income	(4,512)	2	13
14	Bad Debt Expense	(1,875)	21	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	<b>Total</b>	(50,494)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

**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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,512)	0	0	0	0	0	0	0	0	0	0	(4,512)	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	752	0	0	0	0	0	0	0	0	0	752	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,512)</b>	<b>752</b>	<b>0</b>	<b>(3,760)</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	(23,863)	0	0	0	0	0	0	0	0	0	(23,863)	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)	187	0	0	0	0	0	0	0	0	0	(562)	20
21	Clerical & General Office Expenses	(4,616)	8,599	0	0	0	0	0	0	0	0	0	3,983	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	<b>TOTAL General Administration</b>	<b>(5,365)</b>	<b>(15,077)</b>	<b>0</b>	<b>(20,442)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(9,877)</b>	<b>(14,325)</b>	<b>0</b>	<b>(24,202)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

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

# 0026765

Report Period Beginning:

1/1/2007 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	0	2,071	0	0	0	0	0	0	0	0	0	2,071	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,158)	14,773	0	0	0	0	0	0	0	0	0	(4,385)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	10,450	0	0	0	0	0	0	0	0	0	10,450	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>(19,158)</b>	<b>27,294</b>	<b>0</b>	<b>8,136</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):*	(130,505)	0	0	0	0	0	0	0	0	0	0	(130,505)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(130,505)</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>(130,505)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(159,540)</b>	<b>12,969</b>	<b>0</b>	<b>(146,571)</b>	<b>45</b>								

Facility Name &amp; ID Number

Burgin Manor of Olney, Inc.# 0026765

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

## 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>University City</u>	<u>Management Co.</u>
<u>Shirley Axelbaum</u>	<u>30.56</u>			<u>Management, Inc.</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>					
<u>Steven Axelbaum</u>	<u>1.01</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>251,886</u>	<u>Burgin Healthcare Mgmt, Inc.</u>		\$ <u>228,023</u>	\$ <u>(23,863)</u>	1
2	V	<u>21</u> <u>Tax &amp; License</u>		<u>Burgin Healthcare Mgmt, Inc.</u>		<u>451</u>	<u>451</u>	2
3	V	<u>21</u> <u>Admin &amp; Clerical</u>		<u>Burgin Healthcare Mgmt, Inc.</u>		<u>7,364</u>	<u>7,364</u>	3
4	V	<u>6</u> <u>Plant Operation</u>		<u>Burgin Healthcare Mgmt, Inc.</u>		<u>752</u>	<u>752</u>	4
5	V	<u>30</u> <u>Depreciation</u>		<u>Burgin Healthcare Mgmt, Inc.</u>		<u>2,071</u>	<u>2,071</u>	5
6	V	<u>32</u> <u>Interest</u>		<u>Burgin Healthcare Mgmt, Inc.</u>		<u>14,773</u>	<u>14,773</u>	6
7	V	<u>34</u> <u>Rent</u>		<u>Burgin Healthcare Mgmt, Inc.</u>		<u>10,450</u>	<u>10,450</u>	7
8	V	<u>21</u> <u>Equip Rental</u>		<u>Burgin Healthcare Mgmt, Inc.</u>		<u>693</u>	<u>693</u>	8
9	V	<u>20</u> <u>Dues &amp; Subscriptions</u>		<u>Burgin Healthcare Mgmt, Inc.</u>		<u>187</u>	<u>187</u>	9
10	V	<u>21</u> <u>Misc.</u>		<u>Burgin Healthcare Mgmt, Inc.</u>		<u>91</u>	<u>91</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>251,886</u>			\$ <u>264,855</u>	\$ * <u>12,969</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: 1/1/2007 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	N/A								\$	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:

1/1/2007

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

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	17	Mgmt Fees	Direct Costs	1	\$ 228,023	\$	1	\$ 228,023	1
2	17	Officer Salaries	Direct Costs	1	451		1	451	2
3	21	Tax & License	Direct Costs	1	7,364		1	7,364	3
4	21	Clerical Expenses	Direct Costs	1	752		1	752	4
5	35	Equipment	Direct Costs	1	2,071		1	2,071	5
6	30	Depreciation	Direct Costs	1	14,773		1	14,773	6
7	32	Interest	Direct Costs	1	10,450		1	10,450	7
8	34	Rent	Direct Costs	1	693		1	693	8
9	21	Misc.	Direct Costs	1	187		1	187	9
10	6	Plant Operation	Direct Costs	1	91		1	91	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				\$ 264,855	\$		\$ 264,855	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	US Bank		X	Mortgage	\$3,100 + Int	10/4/02	\$ 2,245,000	\$	10/4/07	Libor + 2.3	\$ 86,351	1								
2	Toyota Financial Services		X	2004 Camry	5 yrs. 5.074%	3/17/04	21,595	5,539	3/17/09	5.0740	405	2								
3	Chase Auto Finance		X	2003 Audi	5 yrs. 7.886 %	4/28/06	33,927	24,063	4/28/11	7.8860	2,160	3								
4	Heartland Bank		X	Mortgage	5 yrs. 6.49%	10/4/07	2,435,805	2,426,422	10/4/12	6.4900	42,547	4								
5												5								
<b>Working Capital</b>																				
6	US Bank		X	Operating	Interest	10/4/02	494,925		10/4/07	Libor + 2.5%	9,609	6								
7	Various		X	Various	Various	Various			Various	Various	2,451	7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 5,231,252	\$ 2,456,024			\$ 143,523	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>						\$ 5,231,252	\$ 2,456,024			\$ 143,523	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.)

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

# 0026765 Report Period Beginning: 1/1/2007

Ending: 12/31/2007

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.	\$	<u>80,199</u>	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.)	\$	<u>80,332</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>133</u>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>80,331</u>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<u>80,464</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<u>77,254</u>	8
	2003	<u>73,238</u>	9
	2004	<u>73,238</u>	10
	2005	<u>75,786</u>	11
	2006	<u>80,199</u>	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 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 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 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>1-0635-350-001</u>	<u>See Attached</u>	\$ <u>31,133.16</u>	\$ <u>31,133.16</u>
2. <u>1-0635-350-002</u>	<u>See Attached</u>	\$ <u>49,198.20</u>	\$ <u>49,198.20</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>80,331.36</u>	\$ <u>80,331.36</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 Burgin Manor of Olney, Inc.

# 0026765 Report Period Beginning:

1/1/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 41,617 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

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	<u>Resident Care</u>	<u>234,725</u>		<u>\$ 75,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>234,725</b>		<b>\$ 75,000</b>	<b>3</b>

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

Report Period Beginning:

**1/1/2007**

Ending:

**12/31/2007****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	19,199	39	19,199		246,345	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Aspen Lighting		1997	1997	739		7			739	9
10	Fire Alarm		1997	1997	1,316		7			1,316	10
11	Beds*		1997	1997	30,726		7			30,726	11
12	Flooring and Carpet		1994	1994	3,946		7			3,946	12
13	Aspen Courtyard		1994	1994	9,539	568	15	568		8,616	13
14	Fence-Aspen		1994	1994	1,079	63	15	63		984	14
15	Windows/Doors		1994	1994	19,291	495	39	495		6,657	15
16	Roof Ambulance Entrance		1994	1994	2,388	61	39	61		814	16
17	1989 Additions		1989	1989	10,163		10			10,163	17
18	1990 Additions		1990	1990	12,277		10			12,277	18
19	1991 Building Improvement		1991	1991	28,943	919	31	919		15,314	19
20	Ceiling Tile		1992	1992	3,542	112	31	112		1,710	20
21	Doors		1993	1993	1,928	49	39	49		706	21
22	Tile Flooring		1993	1993	14,085	447	31	447		6,577	22
23	Sprinkler System		1993	1993	800	25	31	25		376	23
24	Hand Rails		1993	1993	205	5	39	5		75	24
25	Glass Doors		1993	1993	1,456	37	39	37		536	25
26	Nurses Station		1993	1993	1,222	39	31	39		571	26
27	Paint & Wallpaper		1993	1993	26,202	655	40	655		10,782	27
28	Hall Lights		1992	1992	4,383	139	31	139		2,104	28
29	1986 Additions		1986	1986	24,917		19			24,917	29
30	Remodel PT Room		1994	1994	440	11	39	11		137	30
31	Flooring PT Room		1995	1995	1,328	34	39	34		414	31
32	Floor Tile		1995	1995	732	19	39	19		232	32
33	Carpet		1995	1995	786	20	39	20		248	33
34	Architect Fees		1996	1996	6,263		7			6,263	34
35	Cabinets Countertops		1996	1996	10,115		7			10,115	35
36	Therapy Tub		1996	1996	13,348		7			13,348	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:

1/1/2007

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	Flooring Carpet Tile	1996	\$ 24,840	\$	7	\$	\$	\$ 24,840	37
38	Awnings	1996	3,595	209	15	209		2,865	38
39	Sidewalk repairs	1996	910	53	15	53		725	39
40	Air Conditioner	1996	1,699		7			1,699	40
41	Outdoor Lighting	1996	161		7			161	41
42	Air Conditioner System	1996	25,780		7			25,780	42
43	Room Signs	1996	893		7			893	43
44	Soffit	1998	16,899	433	39	433		4,098	44
45	Lights CTR Hall West	1998	1,085	28	39	28		265	45
46	Lights CTR Hall East	1998	701	18	39	18		176	46
47	Lights E Hall West	1998	1,670	43	39	43		409	47
48	Carpet	1997	498		7			498	48
49	Door Closers	1998	1,062		7			1,062	49
50	Lighting Improvements	1998	9,850	253	39	253		2,452	50
51	Carpet for employee break room	1999	296		7			296	51
52	Carpet for Aspen Dining	1999	888		7			888	52
53	West Building Nurse Station Crop Ceiling	1999	531	14	39	14		119	53
54	Aspen Drop Ceiling	1999	1,221	31	39	31		271	54
55	Electrical Panel west building	2000	1,164	52	7	52		1,164	55
56	Ceiling Fans	2001	1,359	49	27	49		344	56
57	Architectural svcs	2001	12,131	441	27	441		2,959	57
58	Drywalling	2001	919	33	27	33		227	58
59	BDR Converted to Dining Room in Aspen	2001	1,103	40	27	40		256	59
60	Room Bathroom Flooring	2002	255	9	27	9		48	60
61	Roof on West Building	2003	47,312	1,720	27	1,720		7,333	61
62	Tile Flooring for East Dining Room	2003	2,236	81	27	81		403	62
63	Aspen Lighting	2003	1,219		7			1,219	63
64	Roof on East Building	2004	36,916	1,342	27	1,342		4,643	64
65	Generator	2004	25,671	934	27	934		2,995	65
66	New Handrails iin East Building	2004	3,252	118	27	118		399	66
67	Exterior Door for Laundry	2004	950	35	27	35		117	67
68	Medicare Wing Room Liights	2004	1,822		7			1,822	68
69	Concrete floor for Laundry	2005	1,119	41	27	41		97	69
70	TOTAL (lines 4 thru 69)		\$ 2,798,909	\$ 28,874		\$ 28,874	\$	\$ 2,018,531	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:

1/1/2007

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>		\$ 2,798,909	\$ 28,874		\$ 28,874	\$	\$ 2,018,531	1
2	Air Conditioner & Heating	2006	27,340	994	27	994		1,707	2
3	Duct Work for Air Conditioner	2006	552	20	27	20		36	3
4	New Flooring for W Dldg Dining Room	2007	5,100	85	27	85		85	4
5	Replacement Faucets for W Bldg	2007	1,995	21	27	21		21	5
6	W Bldg Main Sewer Line in Basement	2007	8,434	38	27	38		38	6
7	Driveway	1997	8,461	491	15	491		6,248	7
8	1991 Land Improvement	1991	622		15			622	8
9	Landscaping	1992	1,112	33	15	33		1,112	9
10	Asphalt Repairs	1995	455		10			455	10
11	Courtyard Trees	1996	821		7			821	11
12	Backhoe Parking Lot	1996	135		7			135	12
13	Truck Labor	1996	70		7			70	13
14	Concrete pads mix	1996	330		7			330	14
15	Concrete Pads screws	1996	177		7			177	15
16	Landscaping	1998	1,292	75	15	75		880	16
17	Fencing	1998	15,209	883	15	883		10,352	17
18	Parking Lot	1998	23,912	1,388	15	1,388		16,276	18
19	Landscaping	1997	2,287	133	15	133		1,690	19
20	Sidewalk	1999	10,278	611	15	611		6,307	20
21	Driveway	1999	19,536	1,164	15	1,164		11,515	21
22	Concrete Pad for Dumpster Site	2000	906	53	15	53		505	22
23	New Parking Lot for East Bldg	2006	11,300	1,074	15	1,074		1,639	23
24	116 Lamps	2000	5,503	246	7	246		5,502	24
25	Electrical Fixtures	2000	3,761	168	7	168		3,761	25
26	Alalrm System	2000	10,261	458	7	458		12,261	26
27	70 Overbed tables	2000	5,670	253	7	253		7,765	27
28	73 drawer cabinets	2000	19,256	859	7	859		19,256	28
29	Drapes, valances, & bedspreads	2000	23,184	1,035	7	1,035		23,184	29
30	sidewalks	2000	14,236	841	15	841		7,931	30
31	65 chairs	2000	11,939	533	7	533		11,939	31
32	Remodeling	2000	8,255	368	7	368		8,255	32
33	Floor tiling and wallpapering	2000	3,799	170	7	170		3,799	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,045,097	\$ 40,868		\$ 40,868	\$	\$ 2,183,205	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	\$ 559,267	\$ 10,293	\$ 10,293	\$		\$ 539,872	71
72	Current Year Purchases	19,400	17,483	17,483			19,400	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 578,667	\$ 27,776	\$ 27,776	\$		\$ 559,272	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	\$	\$	\$		\$ 3,780	76
77	Facility Use	2000 Ford 13 passenger Van	2000	42,810	1,775	1,775			19,785	77
78	Facility Use	Toyota Avalon	2001	17,000	765	765			17,000	78
79	Facility Use	See Schedule F Below	Various	57,395	4,975	4,975			25,076	79
80	TOTALS			\$ 120,985	\$ 7,515	\$ 7,515	\$		\$ 65,641	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)		\$ 3,819,749	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 76,159	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 76,159	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)		\$ 2,808,118	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	2004 Toyota Camry (acquired 04)	\$ 24,399	\$ 1,175	\$ 17,316	86
87	2003 Audi (acquired 2006)	32,996	3,800	7,760	87
88					88
89					89
90					90
91	TOTALS	\$ 57,395	\$ 4,975	\$ 25,076	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	<b>TOTAL</b>				\$ _____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 20,561 Description: IVAC Pumps \$2544, Specialty Beds \$12,276, Oxygen Ceoncentrators \$4,637, Misc. \$1,104

(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	<b>TOTAL</b>		\$ _____	\$ _____	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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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:1/1/2007

Ending:

12/31/2007

## 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	10a	hrs	\$	2,968	\$ 183,624	\$ 1,516	2,968	\$ 185,140	1
2	Licensed Speech and Language Development Therapist	10a	hrs		743	53,246		743	53,246	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		3,580	222,471	454	3,580	222,925	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			\$	7,291	\$ 459,341	\$ 1,970	7,291	\$ 461,311	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 Burgin Manor of Olney, Inc.# 0026765Report Period Beginning: 1/1/2007

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 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 476,897	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	793,533		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	66,370		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Loan Costs</u>	281,827		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,618,627	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	171,903		13
14	Buildings, at Historical Cost	2,948,194		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	695,413		16
17	Accumulated Depreciation (book methods)	(2,803,880)		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): <u>Due From Accounts</u>	549,434		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,561,064	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,179,691	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 163,073	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	183,914		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Misc.</u>	128,404		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 475,391	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,458,182		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>	\$ 2,458,182	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,933,573	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 246,118	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,179,691	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>235,602</b>	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>235,602</b>	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	<b>315,516</b>	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	<b>(305,000)</b>	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>10,516</b>	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>246,118</b>	24 *

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

Facility Name & ID Number Burgin Manor of Olney, Inc.# 0026765Report Period Beginning: 1/1/2007Ending: 12/31/2007**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	\$ 6,958,281	1
2	Discounts and Allowances for all Levels	(1,057,439)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,900,842</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	549,273	6
7	Oxygen	24,287	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 573,560</b>	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	27,242	13
14	Non-Patient Meals	4,513	14
15	Telephone, Television and Radio	7,889	15
16	Rental of Facility Space		16
17	Sale of Drugs	146,358	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	159,237	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 345,239</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	19,158	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 19,158</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending Income</b>	13,927	28
28a	<b>Misc.</b>	58,279	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 72,206</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,911,005</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,294,284	31
32	Health Care	3,333,336	32
33	General Administration	1,407,520	33
<b>B. Capital Expense</b>			
34	Ownership	324,545	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	150,394	35
36	Provider Participation Fee	85,410	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,595,489</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>315,516</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 315,516</b>	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: 1/1/2007

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	2,077	2,306	\$ 64,409	\$ 27.93	1
2	Assistant Director of Nursing	1,957	2,151	44,538	20.71	2
3	Registered Nurses	37,414	40,947	786,027	19.20	3
4	Licensed Practical Nurses	20,114	21,038	329,527	15.66	4
5	CNAs & Orderlies	109,196	113,577	1,085,566	9.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,962	3,322	39,277	11.82	8
9	Activity Director	2,051	2,085	27,634	13.25	9
10	Activity Assistants	14,078	14,411	111,778	7.76	10
11	Social Service Workers	1,915	1,954	19,066	9.76	11
12	Dietician					12
13	Food Service Supervisor	2,047	2,367	41,394	17.49	13
14	Head Cook	10,550	11,022	95,177	8.64	14
15	Cook Helpers/Assistants	24,077	24,536	184,974	7.54	15
16	Dishwashers					16
17	Maintenance Workers	5,327	5,615	69,792	12.43	17
18	Housekeepers	17,216	17,899	148,017	8.27	18
19	Laundry	11,921	12,270	100,962	8.23	19
20	Administrator	2,085	2,285	74,029	32.40	20
21	Assistant Administrator	1,535	1,668	31,227	18.72	21
22	Other Administrative					22
23	Office Manager	1,903	2,124	43,521	20.49	23
24	Clerical	3,539	3,869	51,377	13.28	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)	271,964	285,446	\$ 3,348,292 *	\$ 11.73	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	197	\$ 10,349	Line 1 (3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	62	2,801	Line 10a (3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	68	Line 10a (3)	43
44	Activity Consultant	24	1,674	Line 11 (3)	44
45	Social Service Consultant	22	1,525	Line 12 (3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	307	\$ 16,417		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: 1/1/2007

Ending: 12/31/2007

**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			74,029	Unemployment Compensation Insurance		Advertising: Employee Recruitment	36	
Una Tarpley			31,226	FICA Taxes		Health Care Worker Background Check	1,327	
				Employee Health Insurance	178,011	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Other IL HC Assn. Dues	9,970	
				Employee Morale	18,181	Quality Assurance	268	
				Other Employee Benefits	532,847	Various Books / Subscriptions	1,705	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 105,255					
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 Col. 7			\$ 251,886				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 251,886				Seminar Expense	
(Attach a copy of any management service agreement)							Seminar	1,853
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 20, col. 8)	
Vendor/Payee	Type		Amount					
Cunningham Acct. Svc	Accountinig		8,700					
Stone Carlie & Co.	Accountinig		9,679					
BKD, LLP	Accountinig		6,250					
Tom Weber & Rosenblum	Legal		1,578					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 26,207					

\* 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 \$8611.20
- (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? \_\_\_\_\_
- (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. \$ 36,439 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (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. \$ 11,934  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
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. N/A
- (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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.