

Facility Name & ID Number BURGIN MANOR OF OLNEY INC

0026765 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	157	Skilled (SNF)	157	57,305	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	157	TOTALS	157	57,305	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	22,517	20,610	5,158	48,285	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,517	20,610	5,158	48,285	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.26%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 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 157 and days of care provided 4,268

Medicare Intermediary WPS, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	394,178	21,816	16,690	432,684		432,684		432,684		1
2	Food Purchase		402,588		402,588		402,588	(6,704)	395,884		2
3	Housekeeping	174,624	29,733	2,615	206,972		206,972		206,972		3
4	Laundry	184,389	34,005	764	219,158		219,158		219,158		4
5	Heat and Other Utilities			148,787	148,787		148,787		148,787		5
6	Maintenance	68,307	62,326	98,517	229,150		229,150		229,150		6
7	Other (specify):*										7
8	TOTAL General Services	821,498	550,468	267,373	1,639,339		1,639,339	(6,704)	1,632,635		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,699,463	140,237	7,683	2,847,383		2,847,383		2,847,383		10
10a	Therapy		881	755,249	756,130		756,130		756,130		10a
11	Activities	192,856	4,686	1,981	199,523		199,523		199,523		11
12	Social Services	62,954	702	7,503	71,159		71,159		71,159		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,955,273	146,506	779,616	3,881,395		3,881,395		3,881,395		16
	C. General Administration										
17	Administrative	149,487		204,000	353,487		353,487	3,237	356,724		17
18	Directors Fees										18
19	Professional Services			57,618	57,618		57,618		57,618		19
20	Dues, Fees, Subscriptions & Promotions			17,858	17,858		17,858	(754)	17,104		20
21	Clerical & General Office Expenses	212,642	21,701	249,983	484,326		484,326	(8,404)	475,922		21
22	Employee Benefits & Payroll Taxes			865,759	865,759		865,759	(16,262)	849,497		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,570	12,570		12,570		12,570		24
25	Other Admin. Staff Transportation			16,377	16,377		16,377		16,377		25
26	Insurance-Prop.Liab.Malpractice			71,262	71,262		71,262		71,262		26
27	Other (specify):*										27
28	TOTAL General Administration	362,129	21,701	1,495,427	1,879,257		1,879,257	(22,183)	1,857,074		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,138,900	718,675	2,542,416	7,399,991		7,399,991	(28,887)	7,371,104		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: 01/01/2014 Ending: 12/31/2014

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	
	D. Ownership											
30	Depreciation			101,705	101,705		101,705	204	101,909			30
31	Amortization of Pre-Op. & Org.			4,987	4,987	(4,987)						31
32	Interest			139,012	139,012	4,987	143,999	(8,466)	135,533			32
33	Real Estate Taxes			107,697	107,697		107,697		107,697			33
34	Rent-Facility & Grounds							7,200	7,200			34
35	Rent-Equipment & Vehicles			31,067	31,067		31,067		31,067			35
36	Other (specify):*											36
37	TOTAL Ownership			384,468	384,468		384,468	(1,062)	383,406			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		170,097	51,500	221,597		221,597		221,597			39
40	Barber and Beauty Shops			15,811	15,811		15,811		15,811			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			353,122	353,122		353,122		353,122			42
43	Other (specify):* nonallowable			93,838	93,838		93,838	(93,838)				43
44	TOTAL Special Cost Centers		170,097	514,271	684,368		684,368	(93,838)	590,530			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,138,900	888,772	3,441,155	8,468,827		8,468,827	(123,787)	8,345,040			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: **01/01/2014**

Ending: **12/31/2014**

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	(1,140)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,231)	21		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	(8,466)	32		10
11	Discounts, Allowances, Rebates & Refunds	(5,564)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25,036)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(16,262)	22		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,100)	21		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	(38,832)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,079)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(27,718)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (134,428)		\$	30

BHF USE ONLY					
48		49		50	51
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (134,428)		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		N	15,811	40	41
42	Laboratory and Radiology		N	51,500	39	42
43	Prescription Drugs		N	111,107	39	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 178,418		47

STATE OF ILLINOIS
 BURGIN MANOR OF OLNEY INC

Report Period Beginning: 01/01/2014
 Ending: 12/31/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	CABLE TV EXPENSES	\$ (4,944)	43	1
2	VENDING MACHINE EXPENSES	(6,432)	43	2
3	LOBBYING EXPENSES	(754)	20	3
4	NEWSCOOP	(4,210)	43	4
5	PUBLIC RELATIONS	(6,394)	43	5
6	GOLDEN FRIENDSHIP	(581)	43	6
7	RESIDENT/FAMILY RELATIONS	(4,205)	43	7
8	MARKETING SUPPLIES	(125)	43	8
9	RESIDENT PURCHASES	(73)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(27,718)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURGIN MANOR OF OLNEY INC# 0026765

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,704)	0	0	0	0	0	0	0	0	0	0	(6,704)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,704)	0	0	0	0	0	0	0	0	0	0	(6,704)	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	3,237	0	0	0	0	0	0	0	0	0	3,237	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	(754)	0	0	0	0	0	0	0	0	0	0	(754)	20
21	Clerical & General Office Expenses	(8,404)	0	0	0	0	0	0	0	0	0	0	(8,404)	21
22	Employee Benefits & Payroll Taxes	(16,262)	0	0	0	0	0	0	0	0	0	0	(16,262)	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	(25,420)	3,237	0	(22,183)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,124)	3,237	0	(28,887)	29								

STATE OF ILLINOIS

Facility Name & ID Number BURGIN MANOR OF OLNEY INC# 0026765

Report Period Beginning:

01/01/2014 Ending:

Summary B

12/31/2014

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	204	0	0	0	0	0	0	0	0	0	204	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,466)	0	0	0	0	0	0	0	0	0	0	(8,466)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	7,200	0	0	0	0	0	0	0	0	0	7,200	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,466)	7,404	0	(1,062)	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):*	(93,838)	0	0	0	0	0	0	0	0	0	0	(93,838)	43
44	TOTAL Special Cost Centers	(93,838)	0	0	0	0	0	0	0	0	0	0	(93,838)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(134,428)	10,641	0	(123,787)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SHIRLEY AXELBAUM	61.12			BURGIN MANOR MC	UNIVERSITY CITY	MANAGEMENT C
BRUCE AXELBAUM	18.43			BURGIN MANOR MC	UNIVERSITY CITY	MANAGEMENT C
RICHARD AXELBAUM	9.72			BURGIN MANOR MC	UNIVERSITY CITY	MANAGEMENT C
STEVEN AXELBAUM	1.01			BURGIN MANOR MC	UNIVERSITY CITY	MANAGEMENT C
DAVID AXELBAUM	5.32			BURGIN MANOR MC	UNIVERSITY CITY	MANAGEMENT C
DAVID AXELBAUM TRUST	4.4			BURGIN MANOR MC	UNIVERSITY CITY	MANAGEMENT C

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 204,000		\$ 207,237	\$ 3,237	1
2	V	34	RENT			7,200	7,200	2
3	V	30	DEPRECIATION			204	204	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 204,000			\$ 214,641	\$ * 10,641	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014

Ending: 2/31/2014

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 MANAGEMENT
 Street Address 8220 DELMAR
 City / State / Zip Code UNIVERSITY CITY, MO
 Phone Number (314) 692 - 0777
 Fax Number (314) 692 - 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	MANAGEMENT FEES	DIRECT COSTS	1	\$	0	1	0	1
2	34	RENT	DIRECT COSTS	1		0	1	0	2
3	30	DEPRECIATION	DIRECT COSTS	1		0	1	0	3
4	0	0	DIRECT COSTS	1		0	1	0	4
5	0	0	DIRECT COSTS	1		0	1	0	5
6	0	0	DIRECT COSTS	1		0	1	0	6
7	0	0	DIRECT COSTS	1		0	1	0	7
8	0	0	DIRECT COSTS	1		0	1	0	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

BURGIN MANOR OF OLNEY INC

0026765

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	HEARTLAND BANK		X	MORTGAGE	5yrs @ 5.5%	10/01/12	\$ 2,208,705	\$	10/01/17	0.0550	\$ 82,186	1					
2	JEFFERSON BANK & TRUST		X	MORTGAGE	5yrs @ 3.5%	07/10/14	3,000,000	2,956,497	07/10/2019	0.0350	43,491	2					
3	CHASE AUTO FINANCE		X	2013 CAMRY	5yrs @ 3.74%	12/18/13	28,664	23,358	12/18/18	0.0374	998	3					
4												4					
5												5					
Working Capital																	
6	HEARTLAND BANK		X	Operating Line of Credit	1yr Variable	VARIOUS	605,513		VARIABLE	VARIABLE	8,090	6					
7	JEFFERSON BANK & TRUST		X	Operating Line of Credit	1yr @3.75%	07/10/14	330,687	250,000	07/10/15	0.0375	2,568	7					
8	Williams Bros Pharmacy		X	Stand Up Lift Purchase	1 year	12/17/13	3,491				1,679	8					
9	TOTAL Facility Related						\$ 6,177,060	\$ 3,229,855			\$ 139,012	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 6,177,060	\$ 3,229,855			\$ 139,012	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE 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 2013 report.		\$	97,223		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.)		\$	102,460		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	5,237		3										
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	102,460		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.		\$	107,697		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2009	87,125	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2013 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2010	89,666	9												
	2011	92,232	10												
	2012	92,143	11												
	2013	97,223	12												

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.

2013 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 _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-35-350-001</u>	<u>SEE ATTACHED</u>	\$ <u>42,681.10</u>	\$ <u>42,681.10</u>
2. <u>06-35-350-002</u>	<u>SEE ATTACHED</u>	\$ <u>59,778.82</u>	\$ <u>59,778.80</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>102,459.92</u></u>	\$ <u><u>102,459.90</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,617 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories _____

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).

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>RESIDENT CARE</u>	<u>234,725</u>	<u>1982</u>	<u>\$ 75,000</u>	1
2					2
3	TOTALS	<u>234,725</u>		<u>\$ 75,000</u>	3

Facility Name & ID Number BURGIN MANOR OF OLNEY INC

0026765

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		1982	1982	\$ 1,510,000	\$	15	\$	\$	\$ 1,510,000	4
5		1996	1996	826,743	30,063	39	30,063		559,812	5
6		2014		(218,160)					(218,160)	6
7										7
8										8
	Improvement Type**									
9	1986 ADDITIONS		1986	24,917		VARIOUS			24,917	9
10	1989 ADDITIONS		1989	10,163		VARIOUS			10,163	10
11	1990 ADDITIONS		1990	12,277		VARIOUS			12,277	11
12	1991 ADDITIONS		1991	28,943	919	VARIOUS	919		21,746	12
13	1992 ADDITIONS		1992		121	VARIOUS	121			13
14	1993 ADDITIONS		1993	14,085	481	VARIOUS	481		9,707	14
15	1994 ADDITIONS		1994	28,830	498	VARIOUS	498		19,659	15
16	1995 ADDITIONS		1995		3	VARIOUS	3			16
17	1996 ADDITIONS		1996			VARIOUS				17
18	1997 ADDITIONS		1997			VARIOUS				18
19	1998 ADDITIONS		1998	26,749	690	VARIOUS	690		11,351	19
20	1999 ADDITIONS		1999		2	VARIOUS	2			20
21	2001 ADDITIONS		2001	12,131	446	VARIOUS	446		6,047	21
22	2002 ADDITIONS		2002		1	VARIOUS	1			22
23	2003 ADDITIONS		2003	49,548	1,802	VARIOUS	1,802		20,686	23
24	2004 ADDITIONS		2004	62,586	2,282	VARIOUS	2,282		23,569	24
25	2005 ADDITIONS		2005		2	VARIOUS	2			25
26	2006 ADDITIONS		2006	27,893	1,014	VARIOUS	1,014		8,834	26
27	NEW FLOORING FOR W BLDG DINING ROOM		2007		8	27	8			27
28	REPLACEMENT FAUCETS FOR W BLDG		2007		3	27	3			28
29	W BLDG MAIN SEWER LINE IN BASEMENT		2007	8,434	307	27	307		2,186	29
30	SPRINKLER SYSTEM IN E BLDG		2008		2	27	2			30
31	NEW WATER HEATER IN EE BOILER		2008		3	27	3			31
32	LASCO ADA SHOWER		2008		2	27	2			32
33	SPRINKLERS		2010	21,859	795	27	795		3,809	33
34	NEW KITCHEN FLOORING		2010		5	27	5			34
35	AC FOR EAST DINING AREA		2010	12,294	447	27	447		2,105	35
36	SIDEWALKS		2010	14,236	841	15	841		13,816	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:

01/01/2014 Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	1991 ADDITIONS	1991	\$	\$	VARIOUS	\$	\$	\$	37
38	1992 ADDITIONS	1992			VARIOUS				38
39	1995 ADDITIONS	1995			VARIOUS				39
40	1996 ADDITIONS	1996			VARIOUS				40
41	1997 ADDITIONS	1997			VARIOUS				41
42	1998 ADDITIONS	1998	23,912		VARIOUS			23,912	42
43	1999 ADDITIONS	1999	29,814	887	VARIOUS	887		29,814	43
44	2000 ADDITIONS	2000		27	VARIOUS	27			44
45	2006 ADDITIONS	2006	11,300	667	VARIOUS	667		6,963	45
46	PATIO EAST PARKING LOT	2008		75	15	75			46
47	EAST PARKING LOT	2009	24,988	779	15	779		17,979	47
48	ASPEN Dining Room Addition - Contracted Total	2011	285,638	10,211	27	10,211		37,396	48
49	SEISMIC BRACING	2011		2	27	2			49
50	2 Fire Doors and Fire Wall	2011	7,291	270	27	270		976	50
51	Aspen Remodeling Plans Fees	2011	3,863	141	27	141		509	51
52	Architect Fees	2011	15,675	581	27	581		2,100	52
53	Construction Insurance	2011	1,748	65	27	65		235	53
54	Sprinkler System	2011	34,802	1,289	27	1,289		4,659	54
55	6 Smoke Detectors	2011	3,918	145	27	145		524	55
56	Floor Tiling	2011	364	30	27	30		98	56
57	Paint for Walls	2011	314	12	27	12		43	57
58	Abestos Removal	2011	2,700	100	27	100		428	58
59	W. Building Windows	2013	38,659	1,406	27	1,406		1,447	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,958,514	\$ 57,424		\$ 57,424	\$	\$ 2,169,607	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 12,078	\$ 786	\$ 786	\$		\$ 8,905	71
72	Current Year Purchases	36,620	36,620	36,620			36,620	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 48,698	\$ 37,406	\$ 37,406	\$		\$ 45,525	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FORD RANGER	92 FORD RANGER	1996	\$ 3,780	\$	\$	\$		\$ 3,780	76
77	FORD PASSENGER	2000 I3 PASSENGER VAN	2000	42,810	1,775	1,775			32,210	77
78										78
79	NON-CARE ASSETS	SEE XI-F	SEE XI-F	74,128	5,100	5,100			61,724	79
80	TOTALS			\$ 120,718	\$ 6,875	\$ 6,875	\$		\$ 97,714	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)	\$ 3,202,930	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,705	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,705	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)	\$ 2,312,846	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	CHEVY VAN WITH LIFT	\$ 21,065	\$	\$ 21,065	86
87	2013 TOYOTA CAMRY	28,664	5,100	16,260	87
88	2004 TOTOTA CAMRY	24,399		24,399	88
89					89
90					90
91	TOTALS	\$ 74,128	\$ 5,100	\$ 61,724	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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ **31,067** Description: **DISHWASHER, IVAC Pumps, Specialty beds, oxygen concentrators**

(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.

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2014 Ending: 12/31/2014
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?</p> <p><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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	5 Cost				
1	Licensed Occupational Therapist		hrs	\$	4,780	\$ 328,057	\$ 381	4,780	\$ 328,438	1
2	Licensed Speech and Language Development Therapist		hrs		1,270	95,869		1,270	95,869	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,958	331,323	500	4,958	331,823	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	11,008	\$ 755,249	\$ 881	11,008	\$ 756,130	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: 01/01/2014Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,320,990	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,419,237		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,017		6
7	Other Prepaid Expenses	68,293		7
8	Accounts Receivable (owners or related parties)	188,836		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,004,373	\$	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	2,958,514		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	169,416		16
17	Accumulated Depreciation (book methods)	(2,312,844)		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>LOAN COSTS</u>	3,741		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 893,827	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,898,200	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 268,168	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	273,358		29
30	Accrued Salaries Payable	155,247		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	102,460		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>OTHER MISC LIABILITIES</u>	208,901		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,008,134	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,381		39
40	Mortgage Payable	2,956,497		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)	\$ 2,958,878	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,967,012	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 931,188	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,898,200	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,323,766	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,323,766	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	139,946	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	(532,525)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (392,578)	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)	\$ 931,188	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 8,492,833	1	
2	Discounts and Allowances for all Levels	(1,332,159)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,160,674	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,026,955	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,026,955	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	15,848	13	
14	Non-Patient Meals	1,140	14	
15	Telephone, Television and Radio	11,695	15	
16	Rental of Facility Space		16	
17	Sale of Drugs	125,767	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services	178,741	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 333,191	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	8,466	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,466	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	OTHER REVENUE	79,487	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 79,487	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,608,773	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,639,339	31	
32	Health Care	3,881,395	32	
33	General Administration	1,879,257	33	
B. Capital Expense				
34	Ownership	384,468	34	
C. Ancillary Expense				
35	Special Cost Centers	331,246	35	
36	Provider Participation Fee	353,122	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,468,827	40	
41	Income before Income Taxes (line 30 minus line 40)**	139,946	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 139,946	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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: **01/01/2014**

Ending: **12/31/2014**

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	2,086	2,326	\$ 72,036	\$ 30.97	1
2	Assistant Director of Nursing	2,086	2,286	47,385	20.73	2
3	Registered Nurses	32,436	34,058	645,150	18.94	3
4	Licensed Practical Nurses	22,872	24,412	391,247	16.03	4
5	CNAs & Orderlies	115,007	118,889	1,222,830	10.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,737	1,861	20,653	11.10	9
10	Activity Assistants	19,194	19,702	172,203	8.74	10
11	Social Service Workers	4,211	4,545	62,954	13.85	11
12	Dietician					12
13	Food Service Supervisor	2,086	2,366	47,825	20.21	13
14	Head Cook	9,260	9,554	96,783	10.13	14
15	Cook Helpers/Assistants	21,393	21,951	191,187	8.71	15
16	Dishwashers					16
17	Maintenance Workers	4,231	4,539	68,307	15.05	17
18	Housekeepers	17,936	18,858	174,624	9.26	18
19	Laundry	18,001	19,107	184,389	9.65	19
20	Administrator	2,086	2,156	91,890	42.62	20
21	Assistant Administrator	1,558	1,715	57,597	33.58	21
22	Other Administrative					22
23	Office Manager	1,505	1,666	36,551	21.94	23
24	Clerical	7,731	8,340	176,091	21.11	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 C: MDS COOR	15,327	16,795	320,816	19.10	32
33	Other(specify) DIETARY Aides	6,477	6,812	58,382	8.57	33
34	TOTAL (lines 1 - 33)	307,220	321,938	\$ 4,138,900 *	\$ 12.86	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	241	\$ 12,889	L1, C3	35
36	Medical Director		7,200	L9, C3	36
37	Medical Records Consultant		1,329	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,902	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,871	L11, C3	44
45	Social Service Consultant	24	1,871	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	289	\$ 30,062		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

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	
STACY BLUE	ADMIN	0	\$ 91,890	Workers' Compensation Insurance	\$	IDPH License Fee	\$ 0	
UNA TARPLEY	ASST. ADMIN	0	57,597	Unemployment Compensation Insurance		Advertising: Employee Recruitment	1,872	
				FICA Taxes	623,287	Health Care Worker Background Check		
				Employee Health Insurance	171,412	(Indicate # of checks performed <u>45</u>)	1,800	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				401K MATCH	45,369			
				OTHER BENEFITS	25,691	Resident background checks	1,340	
						SUBSCRIPTIONS	2,738	
						DUES	10,108	
						Less: Public Relations Expense	(754)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 149,487	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 865,759		\$ 17,104		
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
BURGIN HEALTH MANAGEMENT			\$ 204,000			\$	Out-of-State Travel	\$ 1,175
							In-State Travel	9,026
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 204,000				Seminar Expense	2,369
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 57,618	TOTAL		\$	TOTAL	\$ 12,570

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number **BURGIN MANOR OF OLNEY INC**# **0026765**Report Period Beginning: **01/01/2014** Ending: **12/31/2014****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 for \$8,729.20
- (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? YES If YES, what is the capacity? 161
- (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? 6 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,116 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. _____
- (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. \$ 85,958
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? Yes Indicate the amount. \$ 1,140
- (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. \$ 12,572
c. What percent of all travel expense relates to transportation of nurses and patients? 42.6%
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? NO
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.