

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: <u>0026765</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>BURGIN MANOR</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> 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.																																															
Address: <u>928 EAST SCOTT</u> <u>OLNEY</u> <u>62450</u>																																																	
Number City Zip Code																																																	
County: <u>RICHLAND</u>																																																	
Telephone Number: <u>(618) 395-2150</u> Fax # <u>(618) 392-2150</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>KEN MARX</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>BKD, LLP</u> <u>211 N BROADWAY, STE 600 ST. LOUIS MO, 63102</u></td></tr><tr><td>(Telephone) <u>(314) 231-5544</u> Fax # <u>(314) 231-9731</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>KEN MARX</u> <u>PARTNER</u>	(Firm Name & Address) <u>BKD, LLP</u> <u>211 N BROADWAY, STE 600 ST. LOUIS MO, 63102</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																																				
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Date of Initial License for Current Owners: <u>04/20/1982</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
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		☐	Trust																																														
		☐	Other _____																																														
In the event there are further questions about this report, please contact:																																																	
Name: <u>KEN MARX</u> Telephone Number: <u>(314) 231-5544</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number BURGIN MANOR

0026765 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	26,940	16,721	5,379	49,040	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,940	16,721	5,379	49,040	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.58%

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 4/20/1982 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 5,379

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number **BURGIN MANOR** # **0026765** Report Period Beginning: **01/01/2011** Ending: **12/31/2011**

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	347,770	18,214	13,134	379,118		379,118		379,118			1
2	Food Purchase		320,857		320,857		320,857	(3,046)	317,811			2
3	Housekeeping	161,988	33,366		195,354		195,354		195,354			3
4	Laundry	131,328	11,562	8,311	151,201		151,201		151,201			4
5	Heat and Other Utilities			153,610	153,610		153,610		153,610			5
6	Maintenance	70,755	14,686	112,994	198,435		198,435		198,435			6
7	Other (specify):*											7
8	TOTAL General Services	711,841	398,685	288,049	1,398,575		1,398,575	(3,046)	1,395,529			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,637,053	197,700	229,527	3,064,280		3,064,280		3,064,280			10
10a	Therapy		687	559,751	560,438		560,438		560,438			10a
11	Activities											11
12	Social Services	216,639	4,716	8,623	229,978		229,978		229,978			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,853,692	203,103	805,101	3,861,896		3,861,896		3,861,896			16
	C. General Administration											
17	Administrative	115,774		173,000	288,774		288,774	(2,071)	286,703			17
18	Directors Fees											18
19	Professional Services			28,247	28,247		28,247		28,247			19
20	Dues, Fees, Subscriptions & Promotions			15,801	15,801		15,801	(754)	15,047			20
21	Clerical & General Office Expenses	122,257	21,974	86,863	231,094		231,094	(42,151)	188,943			21
22	Employee Benefits & Payroll Taxes			896,940	896,940		896,940		896,940			22
23	Inservice Training & Education			1,147	1,147		1,147		1,147			23
24	Travel and Seminar			2,365	2,365		2,365		2,365			24
25	Other Admin. Staff Transportation			22,207	22,207		22,207		22,207			25
26	Insurance-Prop.Liab.Malpractice			73,275	73,275		73,275		73,275			26
27	Other (specify):*											27
28	TOTAL General Administration	238,031	21,974	1,299,845	1,559,850		1,559,850	(44,976)	1,514,874			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,803,564	623,762	2,392,995	6,820,321		6,820,321	(48,022)	6,772,299			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 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			83,592	83,592		83,592		83,592			30
31	Amortization of Pre-Op. & Org.			1,635	1,635		1,635		1,635			31
32	Interest			164,351	164,351		164,351	(9,774)	154,577			32
33	Real Estate Taxes			94,798	94,798		94,798		94,798			33
34	Rent-Facility & Grounds							12,788	12,788			34
35	Rent-Equipment & Vehicles			47,359	47,359		47,359		47,359			35
36	Other (specify):*											36
37	TOTAL Ownership			391,735	391,735		391,735	3,014	394,749			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		16,067		16,067		16,067		16,067			39
40	Barber and Beauty Shops			19,726	19,726		19,726		19,726			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,958	85,958		85,958		85,958			42
43	Other (specify):* NonAllowable			84,430	84,430		84,430	(77,954)	6,476			43
44	TOTAL Special Cost Centers		16,067	190,114	206,181		206,181	(77,954)	128,227			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,803,564	639,829	2,974,844	7,418,237		7,418,237	(122,962)	7,295,275			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,046)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,233)	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	(9,774)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23,671)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(19,922)	21		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	(15,237)	21		24
25	Fund Raising, Advertising and Promotional	(25,981)	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	(29,056)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (135,920)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	12,958		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 12,958		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (122,962)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BURGIN MANOR

	ID#	0026765
Report Period Beginning:		01/01/2011
Ending:		12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	VENDING MACHINE EXPENSE	\$ (5,783)	43	1
2	LOBBYING	(754)	20	2
3	NEWSCOOP	(6,002)	43	3
4	TRANSFER INSURANCE	(11,040)	43	4
5	PUBLIC RELATIONS	(1,891)	43	5
6	GOLDEN FRIENDSHIP	(414)	43	6
7	RESIDENT/ FAMILY RELATIONS	(2,894)	43	7
8	CORPORATE TAXES	(278)	43	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
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26				26
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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	(29,056)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURGIN MANOR # 0026765 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,046)	0	0	0	0	0	0	0	0	0	0	(3,046)	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	(3,046)	0	0	0	0	0	0	0	0	0	0	(3,046)	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	(2,071)	0	0	0	0	0	0	0	0	0	(2,071)	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	(44,392)	2,241	0	0	0	0	0	0	0	0	0	(42,151)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(45,146)	170	0	0	0	0	0	0	0	0	0	(44,976)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(48,192)	170	0	0	0	0	0	0	0	0	0	(48,022)	29

Summary B

12/31/2011

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JERALD AXELBAUM	30.56			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT CO
SHIRLEY AXELBAUM	30.56			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT CO
BRUCE AXELBAUM	18.43			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT CO
RICHARD AXELBAUM	9.72			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT CO
DAVID AXELBAUM	9.72			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT CO
STEVEN AXELBAUM	1.01			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT CO

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	\$ 173,000			\$ 170,929	\$ (2,071)	1
2	V	21	TAXES & LICENSES				538	538	2
3	V	21	CLERICAL EXPENSES				1,703	1,703	3
4	V	34	RENT				12,788	12,788	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			\$ 173,000			\$ 185,958	\$ * 12,958	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 # 0026765 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 # 0026765 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization BURGIN HEALTH MANAGEMENT
Street Address 8220 DELMAR
City / State / Zip Code UNIVERSITY CITY, MO
Phone Number (314) 692-0777
Fax Number (314) 692-0406

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	17	MGMT FEES	DIRECT COSTS	1	\$	170,929	1	\$ 0	1
	2	21	TAXES & LICENSES	DIRECT COSTS	1		538	1	0	2
	3	21	CLERICAL EXPENSES	DIRECT COSTS	1		1,703	1	0	3
	4	34	RENT	DIRECT COSTS	1		12,788	1	0	4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	185,958		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	HEARTLAND BANK		X	MORTGAGE	5 YRS @ 6.49%	10/4/07	\$ 2,343,158	\$ 2,247,739	10/4/12	0.0649	\$ 148,664	1	
2	CHASE AUTO FINANCE		X	2003 AUDI	5 YRS @ 6.49%	4/28/07	10,387		4/28/11	0.0649	230	2	
3	FIRST NATIONAL BANK		X	2006 CHEVY	4 YRS @ 6.25%	2/19/09	16,271	6,371	2/19/13	0.0625	900	3	
4												4	
5												5	
	Working Capital												
6	HEARTLAND BANK		X	OPERATING	1 YR VARIABLE	VARIOUS	605,513	605,513	VARIABLE	VARIABLE	13,252	6	
7	VARIOUS		X	VARIOUS	VARIOUS	VARIOUS			VARIOUS	VARIOUS	1,305	7	
8												8	
9	TOTAL Facility Related						\$ 2,975,329	\$ 2,859,623			\$ 164,351	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,975,329	\$ 2,859,623			\$ 164,351	15	

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	89,666	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.)		\$	92,232	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	2,566	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	92,232	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.		\$	94,798	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	80,199	8	
		2007	80,464	9	
		2008	83,440	10	
		2009	87,125	11	
		2010	89,665	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 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.

FACILITY NAME BURGIN MANOR COUNTY RICHLAND

FACILITY IDPH LICENSE NUMBER 0026765

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(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>1-0635-350-001</u>	<u>SEE ATTACHED</u>	\$ <u>35,745.64</u>	\$ <u>35,745.64</u>
2.	<u>1-0635-350-002</u>	<u>SEE ATTACHED</u>	\$ <u>56,486.08</u>	\$ <u>56,486.08</u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u>92,231.72</u>	\$ <u>92,231.72</u>

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?

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number BURGIN MANOR

0026765

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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	21,199	39	21,199		331,144	5
6											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		18,989	12
13	1992 Additions			1992	7,925	252	Various	252		4,821	13
14	1993 Additions			1993	45,898	1,258	Various	1,258		24,657	14
15	1994 Additions			1994	32,737	567	Various	567		20,495	15
16	1995 Additions			1995	2,846	73	Various	73		1,186	16
17	1996 Additions			1996	20,883	131	Various	131		20,883	17
18	1997 Additions			1997	30,726		Various			30,726	18
19	1998 Additions			1998	30,205	775	Various	775		10,498	19
20	1999 Additions			1999	1,752	45	Various	45		570	20
21	2001 Additions			2001	15,512	564	Various	564		6,042	21
22	2002 Additions			2002	255	9	Various	9		85	22
23	2003 Additions			2003	50,767	1,802	Various	1,802		16,500	23
24	2004 Additions			2004	68,612	2,429	Various	2,429		19,690	24
25	2005 Additions			2005	1,119	41	Various	41		259	25
26	2006 Additions			2006	27,893	1,014	Various	1,014		5,792	26
27	New Flooring For W Bldg Dinning Room			2007	5,100	185	27	185		827	27
28	Replacement Faucets for W Bldg			2007	1,995	73	27	73		311	28
29	W Bldg Main Swer Line in Basement			2007	8,434	307	27	307		1,265	29
30	Sprinkler System in E Bldg			2008	1,284	47	27	47		181	30
31	New Water Heater in EE Boiler			2008	1,764	64	27	64		206	31
32	LASCO Ada Shower			2008	1,514	55	27	55		167	32
33	Sprinklers			2010	21,859	795	27	795		1,424	33
34	New Kitchen Flooring			2010	3,427	125	27	125		161	34
35	AC for East Dining Area			2010	12,294	447	27	447		764	35
36	Sidewalks			2010	14,236	841	15	841		11,294	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

0026765

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 1991 Additions	1991	\$ 622	\$	Various	\$	\$	\$ 622	37
38 1992 Additions	1992	1,112		Various			1,112	38
39 1995 Additions	1995	455		Various			455	39
40 1996 Additions	1996	1,533		Various			1,533	40
41 1997 Additions	1997	10,748	624	Various	624		10,436	41
42 1998 Additions	1998	40,413	2,347	Various	2,347		36,893	42
43 1999 Additions	1999	29,814	1,775	Various	1,775		25,378	43
44 2000 Additions	2000	906	53	Various	53		719	44
45 2006 Additions	2006	11,300	704	Various	704		4,961	45
46 Patio East Parking Lot	2008	5,113	197	15	197		3,343	46
47 East Parking Lot	2009	24,988	1,068	15	1,068		15,374	47
48 ASPEN Dining Room Addition	2011	83,173	1,890	27	1,890		1,890	48
49 Seismic Bracing	2011	932	30	27	30		30	49
50 Aspen Remodeling Costs	2011	269,277	6,120	27	6,120		6,120	50
51 Aspen Remoleling Plans Fee	2011	3,863	88	27	88		88	51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,306,329	\$ 48,913		\$ 48,913	\$	\$ 2,195,248	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	\$ 287,924	\$ 3,821	\$ 3,821	\$	Various	\$ 258,815	71
72	Current Year Purchases	27,308	27,308	27,308			27,308	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 315,232	\$ 31,129	\$ 31,129	\$		\$ 286,123	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	\$	\$	\$	5	\$ 3,780	76
77	FORD VAN	2000 FORD VAN	2000	42,810	1,775	1,775		5	26,885	77
78										78
79	FACILITY USE	SEE SCHEDULE F BELOW	Various	78,460	1,775	1,775		5	61,399	79
80	TOTALS			\$ 125,050	\$ 3,550	\$ 3,550	\$		\$ 92,064	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)	\$ 3,821,611	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 83,592	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,592	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)	\$ 2,573,435	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	\$ 24,399	\$	\$ 24,399	86
87	2003 AUDI	32,996	1,775	15,935	87
88	CHEVY VAN WITH LIFT	21,065		21,065	88
89					89
90					90
91	TOTALS	\$ 78,460	\$ 1,775	\$ 61,399	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

**

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: \$ 30,538
- Description: IVAC PUMPS, SPECIALITY BEDS, OXYGEN CONCENTRATORS, MISC.
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed			Contract	Total
1	Community College Tuition	\$	\$			\$	\$
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	\$			\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	3,431	\$ 211,085	\$	3,431	\$ 211,085	1
2	Licensed Speech and Language Development Therapist		hrs		926	75,891		926	75,891	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,501	272,774		4,501	272,774	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
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10										10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	8,858	\$ 559,750	\$	8,858	\$ 559,750	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 55,747	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,528,410		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,124		6
7	Other Prepaid Expenses	61,022		7
8	Accounts Receivable (owners or related parties)	228,150		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,879,453	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,000		13
14	Buildings, at Historical Cost	3,310,090		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	414,842		16
17	Accumulated Depreciation (book methods)	(2,573,435)		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): LOAN COSTS	360,836		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,587,333	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,466,786	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 244,603	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	605,513		29
30	Accrued Salaries Payable	95,569		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,232		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER MISC LIABILITIES	32,382		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,070,299	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,735		39
40	Mortgage Payable	2,247,739		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)	\$ 2,256,474	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,326,773	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 140,013	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,466,786	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (259,816)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (259,816)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	399,829	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 399,829	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)	\$ 140,013	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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,031,012	1
2	Discounts and Allowances for all Levels	(406,074)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,624,938	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	680,149	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 680,149	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	21,696	13
14	Non-Patient Meals	3,046	14
15	Telephone, Television and Radio	15,703	15
16	Rental of Facility Space		16
17	Sale of Drugs	171,162	17
18	Sale of Supplies to Non-Patients	244,398	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 456,005	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,774	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,774	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER MISC INCOME	47,200	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 47,200	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,818,066	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,398,575	31
32	Health Care	3,861,896	32
33	General Administration	1,559,850	33
	B. Capital Expense		
34	Ownership	391,735	34
	C. Ancillary Expense		
35	Special Cost Centers	120,223	35
36	Provider Participation Fee	85,958	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,418,237	40
41	Income before Income Taxes (line 30 minus line 40)**	399,829	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 399,829	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.

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	2,318	2,318	\$ 75,485	\$ 32.56	1
2	Assistant Director of Nursing	2,286	2,286	50,566	22.12	2
3	Registered Nurses	35,819	35,819	665,329	18.57	3
4	Licensed Practical Nurses	27,073	27,073	430,639	15.91	4
5	CNAs & Orderlies	124,978	124,978	1,243,217	9.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	20,804	20,804	185,044	8.89	9
10	Activity Assistants					10
11	Social Service Workers	2,618	2,618	31,595	12.07	11
12	Dietician	37,191	37,191	347,770	9.35	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,878	4,878	70,755	14.50	17
18	Housekeepers	17,909	17,909	161,988	9.05	18
19	Laundry	14,352	14,352	131,328	9.15	19
20	Administrator	2,305	2,305	82,935	35.98	20
21	Assistant Administrator	1,669	1,669	32,838	19.68	21
22	Other Administrative	6,851	6,851	122,257	17.85	22
23	Office Manager					23
24	Clerical					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) MDS COORD	9,477	9,477	171,818	18.13	33
34	TOTAL (lines 1 - 33)	310,528	310,528	\$ 3,803,564 *	\$ 12.25	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	198	\$ 11,161	LINE 1 (3)	35
36	Medical Director		7,200	LINE 9 (3)	36
37	Medical Records Consultant		1,180	LINE 10 (3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,050	LINE 10 (3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	2,024	LINE 11 (3)	44
45	Social Service Consultant	26	2,024	LINE 12 (3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	250	\$ 30,639		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

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 \$753.60

(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?

7 YRS

(6)

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

\$ 48,666

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?

NO

Indicate the amount.

\$ 0

(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.

\$ 17,734

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

d. Have vehicle usage logs been maintained?

YES

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

NO

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

YES

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

NO

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

\$

(17)

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

NO

Firm Name:

(18)

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