

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 OF OLNEY INC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</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>900 E SCOTT ST</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>KEVIN WELLEN</u> <u>SENIOR MANAGING CONSULTANT</u></td></tr><tr><td>(Firm Name & Address) <u>BKD, LLC</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>KEVIN WELLEN</u> <u>SENIOR MANAGING CONSULTANT</u>	(Firm Name & Address) <u>BKD, LLC</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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	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																								
Date of Initial License for Current Owners: <u>04/20/1982</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</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>KEVIN WELLEN</u> Telephone Number: <u>(314) 231-5544</u>																									
Email Address: _____																									

Facility Name & ID Number BURGIN MANOR OF OLNEY INC# 0026765 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>157</u>	Skilled (SNF)	<u>157</u>	<u>57,462</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	157	TOTALS	157	57,462	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>26,133</u>	<u>18,927</u>	<u>5,969</u>	<u>51,029</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,133	18,927	5,969	51,029	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.80%

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?

YESG. 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 04/20/1982NO ☐

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 5,969Medicare Intermediary WPS, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

	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	369,567	20,906	15,193	405,666		405,666		405,666		1
2	Food Purchase		350,302		350,302		350,302	(6,964)	343,338		2
3	Housekeeping	162,189	38,399		200,588		200,588		200,588		3
4	Laundry	145,765	24,362		170,127		170,127		170,127		4
5	Heat and Other Utilities			151,189	151,189		151,189		151,189		5
6	Maintenance	67,450	10,541	116,128	194,119		194,119		194,119		6
7	Other (specify):*										7
8	TOTAL General Services	744,971	444,510	282,510	1,471,991		1,471,991	(6,964)	1,465,027		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,778,805	210,829	248,932	3,238,566		3,238,566		3,238,566		10
10a	Therapy		1,637	693,108	694,745		694,745		694,745		10a
11	Activities	174,662	4,766	2,101	181,529		181,529		181,529		11
12	Social Services	47,596	1,227	5,974	54,797		54,797		54,797		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,001,063	218,459	957,315	4,176,837		4,176,837		4,176,837		16
	C. General Administration										
17	Administrative	117,987		181,500	299,487		299,487	(15,206)	284,281		17
18	Directors Fees										18
19	Professional Services			65,598	65,598		65,598		65,598		19
20	Dues, Fees, Subscriptions & Promotions			15,860	15,860		15,860	(527)	15,333		20
21	Clerical & General Office Expenses	183,351	27,628	44,062	255,041		255,041	(11,018)	244,023		21
22	Employee Benefits & Payroll Taxes			939,459	939,459		939,459	(19,550)	919,909		22
23	Inservice Training & Education			748	748		748		748		23
24	Travel and Seminar			12,288	12,288		12,288		12,288		24
25	Other Admin. Staff Transportation			13,564	13,564		13,564		13,564		25
26	Insurance-Prop.Liab.Malpractice			75,800	75,800		75,800		75,800		26
27	Other (specify):*										27
28	TOTAL General Administration	301,338	27,628	1,348,879	1,677,845		1,677,845	(46,301)	1,631,544		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,047,372	690,597	2,588,704	7,326,673		7,326,673	(53,265)	7,273,408		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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			73,047	73,047		73,047	552	73,599			30
31	Amortization of Pre-Op. & Org.			3,899	3,899		3,899		3,899			31
32	Interest			183,422	183,422		183,422	(8,635)	174,787			32
33	Real Estate Taxes			92,054	92,054		92,054		92,054			33
34	Rent-Facility & Grounds							7,200	7,200			34
35	Rent-Equipment & Vehicles			34,949	34,949		34,949		34,949			35
36	Other (specify):*											36
37	TOTAL Ownership			387,371	387,371		387,371	(883)	386,488			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,857		17,857		17,857		17,857			39
40	Barber and Beauty Shops			20,221	20,221		20,221		20,221			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			555,314	555,314		555,314		555,314			42
43	Other (specify):* Non-Allowable			88,200	88,200		88,200	(87,360)	840			43
44	TOTAL Special Cost Centers		17,857	663,735	681,592		681,592	(87,360)	594,232			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,047,372	708,454	3,639,810	8,395,636		8,395,636	(141,508)	8,254,128			45

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

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

		1	2	3	
	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	(2,425)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,634)	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	(8,635)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,539)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23,900)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(19,550)	22		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,993)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(12,841)	43		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,848)	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	(29,562)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (140,927)		\$	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)	(581)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (581)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (141,508)		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

STATE OF ILLINOIS
BURGIN MANOR OF OLNEY INC

Page 5A

ID# 0026765
Report Period Beginning: 01/01/2012
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	VENDING MACHINE EXPENSE	\$ (5,880)	43	1
2	LOBBYING	(730)	20	2
3	NEWSCOOP	(5,023)	43	3
4	GAIN ON SALE OF ASSETS	(6,061)	21	4
5	PUBLIC RELATIONS	(3,344)	43	5
6	GOLDEN FRIENDSHIP	(551)	43	6
7	RESIDENT/FAMILY RELATIONS	(3,161)	43	7
8	CORPORATE TAXES	(278)	43	8
9	OTHER EXPENSES	(25)	43	9
10	CABLE TV EXPENSE	(4,509)	43	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	(29,562)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURGIN MANOR OF OLNEY INC

0026765

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	(6,964)	0	0	0	0	0	0	0	0	0	0	(6,964)	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	(6,964)	0	0	0	0	0	0	0	0	0	0	(6,964)	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	(15,206)	0	0	0	0	0	0	0	0	0	(15,206)	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	(730)	203	0	0	0	0	0	0	0	0	0	(527)	20
21	Clerical & General Office Expenses	(17,688)	6,670	0	0	0	0	0	0	0	0	0	(11,018)	21
22	Employee Benefits & Payroll Taxes	(19,550)	0	0	0	0	0	0	0	0	0	0	(19,550)	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	(37,968)	(8,333)	0	0	0	0	0	0	0	0	0	(46,301)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(44,932)	(8,333)	0	0	0	0	0	0	0	0	0	(53,265)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	552	0	0	0	0	0	0	0	0	0	552	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,635)	0	0	0	0	0	0	0	0	0	0	(8,635)	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	(8,635)	7,752	0	0	0	0	0	0	0	0	0	(883)	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):*	(87,360)	0	0	0	0	0	0	0	0	0	0	(87,360)	43
44	TOTAL Special Cost Centers	(87,360)	0	0	0	0	0	0	0	0	0	0	(87,360)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(140,927)	(581)	0	0	0	0	0	0	0	0	0	(141,508)	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
JEROLD AXELBAUM	30.56			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT C
SHIRLEY AXELBAUM	30.56			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT C
BRUCE AXELBAUM	18.43			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT C
RICHARD AXELBAUM	9.72			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT C
STEVEN AXELBAUM	1.01			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT C
DAVID AXELBAUM	5.32			BURGIN HEALTH M	UNIVERSITY CITY	MANAGEMENT C
DAVID AXELBAUM TRUST	4.40			BURGIN HEALTH M	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	\$ 181,500			\$ 166,294	\$ (15,206)	1
2	V	21	TAXES & LICENSES				280	280	2
3	V	21	CLERICAL EXPENSES				6,390	6,390	3
4	V	30	DEPRECIATION				552	552	4
5	V	34	RENT				7,200	7,200	5
6	V	20	DUES & SUBSCRIPTIONS				203	203	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 181,500			\$ 180,919	\$ * (581)	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

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: 01/01/2012 Ending: 2/31/2012

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	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		\$	166,294	1	\$ 0	1
2	21	TAXES & LICENSES	DIRECT COSTS	1			280	1	0	2
3	21	CLERICAL EXPENSES	DIRECT COSTS	1			6,390	1	0	3
4	30	DEPRECIATION	DIRECT COSTS	1			552	1	0	4
5	34	RENT	DIRECT COSTS	1			7,200	1	0	5
6	20	DUES & SUBSCRIPTIONS	DIRECT COSTS	1			203	1	0	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					\$	180,919		\$	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	5yrs @ 6.49%	10/04/07	\$ 2,435,805	\$	10/04/12	0.0649	\$ 110,158	1	
2	HEARTLAND BANK		X	MORTGAGE	5yrs @ 5.50%	10/01/12	2,208,705	2,186,903	10/01/17	0.0550	40,703	2	
3	FIRST NATIONAL BANK		X	2006 CHEVY	4yrs @ 6.25%	02/19/09	20,050	939	02/19/13	0.0625	244	3	
4												4	
5												5	
	Working Capital												
6	HEARTLAND BANK		X	OPERATING	1yr VARIABLE	VARIOUS	605,513	731,497	VARIABLE	VARIABLE	30,952	6	
7	VARIOUS		X	VARIOUS	VARIOUS	VARIOUS			VARIOUS	VARIOUS	1,365	7	
8												8	
9	TOTAL Facility Related						\$ 5,270,073	\$ 2,919,339			\$ 183,422	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,270,073	\$ 2,919,339			\$ 183,422	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 2011 report.		\$	92,232	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.)		\$	92,143	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(89)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	92,143	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.		\$	92,054	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	80,464	8	
		2008	83,440	9	
		2009	87,125	10	
		2010	89,666	11	
		2011	92,232	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 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.

2011 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 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>1-0635-350-001</u>	<u>SEE ATTACHED</u>	\$ <u>35,711.20</u>	\$ <u>35,711.20</u>
2.	<u>1-0635-350-002</u>	<u>SEE ATTACHED</u>	\$ <u>56,431.64</u>	\$ <u>56,431.64</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><u>92,142.84</u></u>	\$ <u><u>92,142.84</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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	1982	\$ 75,000	1
2					2
3	TOTALS	234,725		\$ 75,000	3

Facility Name & ID Number BURGIN MANOR OF OLNEY INC

0026765

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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		352,343	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		19,908	12
13	1992 ADDITIONS			1992	7,925	252	VARIOUS	252		5,072	13
14	1993 ADDITIONS			1993	45,898	1,258	VARIOUS	1,258		25,915	14
15	1994 ADDITIONS			1994	32,737	567	VARIOUS	567		21,063	15
16	1995 ADDITIONS			1995	2,846	73	VARIOUS	73		1,259	16
17	1996 ADDITIONS			1996	20,883		VARIOUS			20,883	17
18	1997 ADDITIONS			1997	30,726		VARIOUS			30,726	18
19	1998 ADDITIONS			1998	30,205	775	VARIOUS	775		11,272	19
20	1999 ADDITIONS			1999	1,752	45	VARIOUS	45		615	20
21	2001 ADDITIONS			2001	15,512	564	VARIOUS	564		6,606	21
22	2002 ADDITIONS			2002	255	9	VARIOUS	9		94	22
23	2003 ADDITIONS			2003	50,767	1,802	VARIOUS	1,802		18,302	23
24	2004 ADDITIONS			2004	68,612	2,429	VARIOUS	2,429		22,119	24
25	2005 ADDITIONS			2005	1,119	41	VARIOUS	41		300	25
26	2006 ADDITIONS			2006	27,893	1,014	VARIOUS	1,014		6,806	26
27	NEW FLOORING FOR W BLDG DINING ROOM			2007	5,100	185	27	185		1,012	27
28	REPLACEMENT FAUCETS FOR W BLDG			2007	1,995	73	27	73		384	28
29	W BLDG MAIN SEWER LINE IN BASEMENT			2007	8,434	307	27	307		1,572	29
30	SPRINKLER SYSTEM IN E BLDG			2008	1,284	47	27	47		228	30
31	NEW WATER HEATER IN EE BOILER			2008	1,764	64	27	64		270	31
32	LASCO ADA SHOWER			2008	1,514	55	27	55		222	32
33	SPRINKLERS			2010	21,859	795	27	795		2,219	33
34	NEW KITCHEN FLOORING			2010	3,427	125	27	125		286	34
35	AC FOR EAST DINING AREA			2010	12,294	447	27	447		1,211	35
36	SIDEWALKS			2010	14,236	841	15	841		12,134	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

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

****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	\$ 289,792	\$ 3,593	\$ 3,593	\$		\$ 285,958	71
72	Current Year Purchases	18,444	17,165	17,165			17,165	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 308,236	\$ 20,758	\$ 20,758	\$		\$ 303,123	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	28,660	77
78										78
79	FACILITY USE	SEE SCHEDULE F BELOW	VARIOUS	45,464				5	45,464	79
80	TOTALS			\$ 92,054	\$ 1,775	\$ 1,775	\$		\$ 77,904	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,785,380 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,700 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,700 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)	\$ 2,633,200 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	CHEVY VAN WITH LIFT	21,065		21,065	87
88					88
89					89
90					90
91	TOTALS	\$ 45,464	\$	\$ 45,464	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?

X

YESNO
- If NO, see instructions.

		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:
- YESNO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES

X

NO
16. Rental Amount for movable equipment: \$34,949Description: 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

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. /2013\$
13. /2014\$
14. /2015\$

* 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.

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

12345678										
	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	\$	4,084	\$ 257,299	\$	4,084	\$ 257,299	1
2	Licensed Speech and Language Development Therapist		hrs		955	70,260		955	70,260	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,772	365,549		5,772	365,549	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	10,811	\$ 693,108	\$	10,811	\$ 693,108	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 239,716	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,983,986		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,440		6
7	Other Prepaid Expenses	105,817		7
8	Accounts Receivable (owners or related parties)	181,624		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,517,583	\$	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	400,290		16
17	Accumulated Depreciation (book methods)	(2,633,200)		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>	393,711		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,545,891	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,063,474	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 219,102	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	731,497		29
30	Accrued Salaries Payable	145,801		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,143		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>OTHER MIS LIABILITIES</u>	260,119		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,448,662	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,308		39
40	Mortgage Payable	2,186,903		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)	\$ 2,190,211	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,638,873	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 424,601	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,063,474	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 130,010	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 130,010	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	294,591	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)	\$ 294,591	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)	\$ 424,601	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BURGIN MANOR OF OLNEY INC# 0026765Report Period Beginning: 01/01/2012Ending: 12/31/2012**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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,623,670	1
2	Discounts and Allowances for all Levels	(1,339,332)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,284,338	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	909,487	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 909,487	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	22,487	13
14	Non-Patient Meals	2,425	14
15	Telephone, Television and Radio	14,372	15
16	Rental of Facility Space		16
17	Sale of Drugs	183,628	17
18	Sale of Supplies to Non-Patients	202,666	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)	\$ 425,578	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,635	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,635	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER MISC INCOME	62,189	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 62,189	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,690,227	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,471,991	31
32	Health Care	4,176,837	32
33	General Administration	1,677,845	33
	B. Capital Expense		
34	Ownership	387,371	34
	C. Ancillary Expense		
35	Special Cost Centers	126,278	35
36	Provider Participation Fee	555,314	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,395,636	40
41	Income before Income Taxes (line 30 minus line 40)**	294,591	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 294,591	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.

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	802	802	\$ 25,130	\$ 31.33	1
2	Assistant Director of Nursing	2,091	2,227	67,744	30.42	2
3	Registered Nurses	31,135	33,734	633,128	18.77	3
4	Licensed Practical Nurses	30,949	32,277	504,124	15.62	4
5	CNAs & Orderlies	130,490	135,408	1,345,769	9.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,894	1,985	20,676	10.42	9
10	Activity Assistants	17,728	18,192	153,986	8.46	10
11	Social Service Workers	3,507	3,590	47,596	13.26	11
12	Dietician					12
13	Food Service Supervisor	2,091	2,303	44,781	19.44	13
14	Head Cook	8,368	8,710	82,039	9.42	14
15	Cook Helpers/Assistants	20,495	20,912	180,841	8.65	15
16	Dishwashers					16
17	Maintenance Workers	4,184	4,600	67,450	14.66	17
18	Housekeepers	16,807	17,746	162,189	9.14	18
19	Laundry	15,442	15,821	145,765	9.21	19
20	Administrator	2,091	2,151	84,735	39.39	20
21	Assistant Administrator	1,491	1,717	33,252	19.37	21
22	Other Administrative					22
23	Office Manager	527	538	11,502	21.38	23
24	Clerical	8,900	9,363	171,849	18.35	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 MDS COORD	9,966	11,127	202,910	18.24	32
33	Other(specify) DIET NUT AIDES	7,169	7,349	61,906	8.42	33
34	TOTAL (lines 1 - 33)	316,127	330,552	\$ 4,047,372 *	\$ 12.24	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	219	\$ 12,206	L1, C3	35
36	Medical Director		7,200	L9, C3	36
37	Medical Records Consultant		1,328	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,226	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	1,867	L11, C3	44
45	Social Service Consultant	24	1,867	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	267	\$ 29,693		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-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	Amount of Expense Amortized Per Year								
					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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$8,666.40
- (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.

\$ 53,188

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.

\$ 555,314

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.

\$ 13,904

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?

YES

Attach invoices and a summary of services for all architect and appraisal fees.