

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0054098 Facility Name: Burgin Manor Address: 900 East Scott St Olney 62450 Number City Zip Code County: Richland Telephone Number: (618) 395-1000 Fax #: (618) 392-2150 HFS ID Number: Date of Initial License for Current Owners: 2/1/2016 Type of Ownership: ☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

In the event there are further questions about this report, please contact:

Name: Steven N. Lavenda Telephone Number: (847) 282-6300

Email Address:

Facility Name & ID Number Burgin Manor

0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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

N/A

	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>52,595</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>157</u>	TOTALS	<u>157</u>	<u>52,595</u>	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	<u>18,389</u>	<u>13,848</u>	<u>3,439</u>	<u>35,676</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,389</u>	<u>13,848</u>	<u>3,439</u>	<u>35,676</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.83%

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

None (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 2/1/2016

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

YES ☒ Date 2/1/2016 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 2,432

Medicare Intermediary WPS, INC

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number **Burgin Manor** # **0054098** Report Period Beginning: **02/01/16** Ending: **12/31/16**
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	252,061	24,103	13,825	289,989		289,989	10,283	300,272			1
2	Food Purchase		294,074		294,074		294,074	(2,249)	291,825			2
3	Housekeeping	168,505	35,228	4,722	208,455		208,455		208,455			3
4	Laundry	78,148	10,809	343	89,300		89,300		89,300			4
5	Heat and Other Utilities			111,524	111,524		111,524	(2,890)	108,634			5
6	Maintenance	77,125	60,185	57,409	194,719		194,719	5,101	199,820			6
7	Other (specify):*							2,416	2,416			7
8	TOTAL General Services	575,839	424,399	187,823	1,188,061		1,188,061	12,661	1,200,722			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	2,057,394	161,136	46,930	2,265,460		2,265,460	(8,628)	2,256,832			10
10a	Therapy	66,282			66,282		66,282		66,282			10a
11	Activities	179,313	8,758	3,933	192,004		192,004		192,004			11
12	Social Services	107,736			107,736		107,736		107,736			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,516	4,516			15
16	TOTAL Health Care and Programs	2,410,725	169,894	57,463	2,638,082		2,638,082	(4,112)	2,633,970			16
	C. General Administration											
17	Administrative	86,711		271,182	357,893		357,893	(210,974)	146,919			17
18	Directors Fees											18
19	Professional Services			267,027	267,027		267,027	(171,419)	95,608			19
20	Dues, Fees, Subscriptions & Promotions			89,647	89,647		89,647	(51,268)	38,379			20
21	Clerical & General Office Expenses	163,887		160,907	324,794		324,794	(3,081)	321,713			21
22	Employee Benefits & Payroll Taxes			551,687	551,687		551,687		551,687			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,358	7,358		7,358	2,733	10,091			24
25	Other Admin. Staff Transportation			46,252	46,252		46,252	11,481	57,733			25
26	Insurance-Prop.Liab.Malpractice			86,506	86,506		86,506	2,330	88,836			26
27	Other (specify):*							15,031	15,031			27
28	TOTAL General Administration	250,598		1,480,566	1,731,164		1,731,164	(405,168)	1,325,996			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,237,162	594,293	1,725,852	5,557,307		5,557,307	(396,618)	5,160,689			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			10,525	10,525		10,525	3,130	13,655			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,606	16,606		16,606	7,020	23,626			32
33	Real Estate Taxes			105,031	105,031		105,031	2,770	107,801			33
34	Rent-Facility & Grounds			522,000	522,000		522,000	(23,392)	498,608			34
35	Rent-Equipment & Vehicles			2,215	2,215		2,215	1,707	3,922			35
36	Other (specify):*			4,070	4,070		4,070	(4,070)				36
37	TOTAL Ownership			660,447	660,447		660,447	(12,834)	647,613			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		132,247	433,187	565,434		565,434		565,434			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			296,236	296,236		296,236		296,236			42
43	Other (specify):*			36,933	36,933		36,933	(36,933)				43
44	TOTAL Special Cost Centers		132,247	766,356	898,603		898,603	(36,933)	861,670			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,237,162	726,540	3,152,655	7,116,357		7,116,357	(446,386)	6,669,971			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				4
5	Telephone, TV & Radio in Resident Rooms	(3,679)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,586)	30		9
10	Interest and Other Investment Income	(7)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,141)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,083)	21		18
19	Entertainment	(3,188)	21		19
20	Contributions	(56,797)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(102,287)	21		24
25	Fund Raising, Advertising and Promotional	(36,933)	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	(4,422)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (213,123)		\$	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)	(233,263)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (233,263)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (446,386)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (8,054)	21	1
2	Theft & Damage Loss	(100)	21	2
3	Amortization	(4,070)	36	3
4	Vening Commissions	(543)	02	4
5	PAC Dues	(1,650)	20	5
6	Non-Allowable Legal	(98)	19	6
7	Credit Card Processing	(121)	21	7
8	Additional R & M	10,214	06	8
9			34	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,422)		49

Burgin Manor

ID#

0054098

Report Period Beginning:

02/01/16

Ending:

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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				10,283								10,283	1
2	Food Purchase	(1,684)		235	(800)								(2,249)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,679)		43			258	489					(2,890)	5
6	Maintenance	10,214		950	(7,014)		463	488					5,101	6
7	Other (specify):*			43	2,167			206					2,416	7
8	TOTAL General Services	4,851		1,271	4,636		721	1,182					12,661	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			4,272	(12,900)								(8,628)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			257	4,259								4,516	15
16	TOTAL Health Care and Programs			4,529	(8,641)								(4,112)	16
	C. General Administration													
17	Administrative			(212,937)		1,963							(210,974)	17
18	Directors Fees													18
19	Professional Services	(98)		(91,994)	933	(75,977)	879	59	(5,222)				(171,419)	19
20	Fees, Subscriptions & Promotions	(58,447)		5,242	1,508	321		108					(51,268)	20
21	Clerical & General Office Expenses	(114,833)		30,132	498	79,746	604	772					(3,081)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,632	1,055	46							2,733	24
25	Other Admin. Staff Transportation			5,888	4,369	1,223							11,481	25
26	Insurance-Prop.Liab.Malpractice			2,108				222					2,330	26
27	Other (specify):*			5,538		9,493							15,031	27
28	TOTAL General Administration	(173,378)		(254,390)	8,363	16,816	1,483	1,161	(5,222)				(405,168)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(168,527)		(248,590)	4,358	16,816	2,204	2,344	(5,222)				(396,618)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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	(3,586)		1,396	214	83	1,118	3,905					3,130	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7)		4,948	17		843	1,218					7,020	32
33	Real Estate Taxes						1,304	1,466					2,770	33
34	Rent-Facility & Grounds			608			(4,000)	(20,000)					(23,392)	34
35	Rent-Equipment & Vehicles			95	413	371	394	434					1,707	35
36	Other (specify):*	(4,070)											(4,070)	36
37	TOTAL Ownership	(7,663)		7,047	644	454	(340)	(12,976)					(12,834)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(36,933)											(36,933)	43
44	TOTAL Special Cost Centers	(36,933)											(36,933)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(213,123)		(241,543)	5,002	17,270	1,863	(10,633)	(5,222)				(446,386)	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
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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)	
15	V	2	FOOD	\$	APERION CARE, INC.	100.00%	\$ 235	\$ 235	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	43	43	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	950	950	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	43	43	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	4,272	4,272	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	257	257	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	58,245	58,245	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	2,340	2,340	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	5,242	5,242	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	30,132	30,132	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,632	1,632	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	5,888	5,888	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	2,108	2,108	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	5,538	5,538	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	1,396	1,396	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	4,948	4,948	30
31	V	34	RENT		APERION CARE, INC.	100.00%	608	608	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	95	95	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	271,182	APERION CARE, INC.	100.00%		(271,182)	35
36	V	19	HOME OFFICE	94,334	APERION CARE, INC.	100.00%		(94,334)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 365,516			\$ 123,973	\$ * (241,543)	39

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

VII. RELATED PARTIES (continued)

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)	
15	V	1	DIETARY	\$	APERION CONSULTING, LLC	100.00%	\$ 10,283	\$ 10,283	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	5,986	5,986	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	2,167	2,167	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	31,900	31,900	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	4,259	4,259	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	933	933	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,508	1,508	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	498	498	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	1,055	1,055	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	4,369	4,369	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	214	214	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	17	17	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	413	413	27
28	V				APERION CONSULTING, LLC	100.00%			28
29	V				APERION CONSULTING, LLC	100.00%			29
30	V				APERION CONSULTING, LLC	100.00%			30
31	V				APERION CONSULTING, LLC	100.00%			31
32	V				APERION CONSULTING, LLC	100.00%			32
33	V				APERION CONSULTING, LLC	100.00%			33
34	V	10	CONSULTING	44,800	APERION CONSULTING, LLC	100.00%		(44,800)	34
35	V	01	DIETICIAN		APERION CONSULTING, LLC	100.00%			35
36	V	02	FOOD SERVICE	800	APERION CONSULTING, LLC	100.00%		(800)	36
37	V	06	PAINTER		APERION CONSULTING, LLC	100.00%			37
38	V	06	PROJECT MANAGER	13,000	APERION CONSULTING, LLC	100.00%		(13,000)	38
39	Total			\$ 58,600			\$ 63,602	\$ * 5,002	39

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

VII. RELATED PARTIES (continued)

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)	
15	V	17	ADMINISTRATIVE	\$	APERION FINANCIAL, LLC	100.00%	\$ 1,963	\$ 1,963	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,542	1,542	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	321	321	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	79,746	79,746	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	46	46	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	1,223	1,223	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	9,493	9,493	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	83	83	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	371	371	23
24	V				APERION FINANCIAL, LLC	100.00%			24
25	V				APERION FINANCIAL, LLC	100.00%			25
26	V				APERION FINANCIAL, LLC	100.00%			26
27	V				APERION FINANCIAL, LLC	100.00%			27
28	V				APERION FINANCIAL, LLC	100.00%			28
29	V				APERION FINANCIAL, LLC	100.00%			29
30	V				APERION FINANCIAL, LLC	100.00%			30
31	V				APERION FINANCIAL, LLC	100.00%			31
32	V				APERION FINANCIAL, LLC	100.00%			32
33	V				APERION FINANCIAL, LLC	100.00%			33
34	V	19	HOME OFFICE EXPENSE	77,519	APERION FINANCIAL, LLC	100.00%		(77,519)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 77,519			\$ 94,789	\$ * 17,270	39

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

VII. RELATED PARTIES (continued)

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)	
15	V	5	UTILITIES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 258	\$ 258	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		463	463	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		879	879	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		604	604	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		1,118	1,118	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		843	843	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		308	308	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		394	394	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,304	1,304	23
24	V								24
25	V								25
26	V	34	RENT	4,308	8131 N. MONTICELLO, LLC			(4,308)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 4,308			\$ 6,171	\$ * 1,863	39

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

VII. RELATED PARTIES (continued)

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.

☒ X

 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)	
15	V	5	UTILITIES	\$	CHASE OFFICE,LLC	100.00%	\$ 489	\$ 489	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		488	488	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		206	206	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		59	59	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		108	108	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		772	772	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		222	222	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		3,905	3,905	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		1,218	1,218	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		1,466	1,466	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		434	434	25
26	V	34	RENT	20,000	CHASE OFFICE,LLC			(20,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 20,000			\$ 9,367	\$ * (10,633)	39

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

VII. RELATED PARTIES (continued)

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.

YESNO

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)	
15	V	19	Payroll Services	\$ 21,758	ProPay HR LLC	24.00%	\$ 16,536	\$ (5,222)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 21,758			\$ 16,536	\$ * (5,222)	39

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

VII. RELATED PARTIES (continued)

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.

YESNO

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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.

YESNO

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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.

YESNO

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* 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	David Berkowitz Delta Trust	22.50%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	Yosef Meystel Delta Trust	22.50%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	David Berkowitz Recovable Trust	22.50%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	Yosef Meystel Recovable Trust	22.50%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	Steven Turofsky	2.00%	Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Frederick S. Frankel	2.00%	Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	Michelle Koder	2.00%	Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	Jeremy Boshes	2.00%	Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	Naftali Wilhelm	2.00%	Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10			Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Forest Park	Forest Park	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Galesburg	Galesburg	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	St. Louis, MO	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Highwood	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Chicago	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Jacksonville	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Kokomo, IN	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Moline	East Moline	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Oak Lawn	Oak Lawn	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Peru	Peru, IN				22
23			Aperion Care Plum Grove	Palatine				23
24			Aperion Care Spring Valley	Spring Valley				24
25			Aperion Care Springfield	Springfield				25
26			Aperion Care St. Elmo	St. Elmo				26
27			Aperion Care Tolleston Park	Gary, IN				27
28			Aperion Care Toluca	Toluca				28
29			Aperion Care Valparaiso	Valparaiso, IN				29
30			Aperion Care Wilmington	Wilmington				30

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			Baypointe Rehab Center	Brockton, MA				1
2			Eastpointe Rehab Center	Chelsea, MA				2
3			Southpointe Rehab Center	Falls River, MA				3
4			The Arbors at Michigan City	Michigan City, IN				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 # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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	Yosef Meystel	Relative	Administrative	0%	See Attached	1.4	3.50%	Alloc. Salary	\$ 6,773	17-7	1
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.7	1.75%	Alloc. Salary	1,046	17-7	2
3	Joel Meystel	Relative	Clerical	0%	See Attached	0.7	3.50%	Alloc. Salary	2,499	21-7	3
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.1	3.03%	Alloc. Salary	1,021	21-7	4
5	Meir Meystel	Relative	Clerical	0%	See Attached	0.2	2.90%	Alloc. Salary	891	21-7	5
6	David Berkowitz	Relative	Administrative	0%	See Attached	1.4	3.50%	Alloc. Salary	6,773	17-7	6
7	Fred Frankel	Owner	Administrative	2.00%	See Attached	1.4	3.50%	Alloc. Salary	6,248	17-7	7
8	Steve Turofsky	Owner	Administrative	2.00%	See Attached	1.4	3.50%	Alloc. Salary	6,495	17-7	8
9	Nosson Factor	Relative	Clerical		See Attached	1.1	3.34%	Alloc. Salary	2,874	21-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 34,620		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 # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	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						\$	\$			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	TOTALS					\$	\$		\$	25

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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 APERION CARE, INC.
Street Address 4655 W CHASE AVENUE
City / State / Zip Code LINCOLNWOOD, ILLINOIS 60712
Phone Number (847) 262-8300
Fax Number (

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	FOOD	ACTUAL CENSUS	1,053,513	34	\$ 6,946	\$	35,676	\$ 235	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265		35,676	43	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	35,676	950	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271		35,676	43	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	35,676	4,272	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576		35,676	257	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	35,676	58,245	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096		35,676	2,340	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783		35,676	5,242	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	35,676	30,132	10
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189		35,676	1,632	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887		35,676	5,888	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237		35,676	2,108	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535		35,676	5,538	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232		35,676	1,396	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102		35,676	4,948	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963		35,676	608	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801		35,676	95	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,660,864	\$ 2,890,119		\$ 123,973	25

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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 APERION CONSULTING, LLC
Street Address 4655 W CHASE AVE
City / State / Zip Code LINCOLNWOOD, ILLINOIS 60712
Phone Number (847) 262-3800
Fax Number (

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY	PATIENT DAYS	1,053,513	34	\$ 303,659	\$ 303,659	35,676	\$ 10,283	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	175,516	35,676	5,986	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982		35,676	2,167	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	941,995	35,676	31,900	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781		35,676	4,259	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541		35,676	933	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521		35,676	1,508	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707		35,676	498	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152		35,676	1,055	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014		35,676	4,369	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318		35,676	214	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508		35,676	17	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204		35,676	413	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					\$ 1,878,156	\$ 1,421,169		\$ 63,602	25

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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 APERION FINANCIAL, LLC
Street Address 4655 W CHASE AVE
City / State / Zip Code LINCOLNWOOD, ILLINOIS 60712
Phone Number (847) 262-3800
Fax Number (

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	\$ 57,979	\$ 57,979	35,676	\$ 1,963	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525		35,676	1,542	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485		35,676	321	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	35,676	79,746	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360		35,676	46	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125		35,676	1,223	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317		35,676	9,493	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458		35,676	83	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954		35,676	371	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					\$ 2,799,102	\$ 2,378,479		\$ 94,789	25

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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 8131 N. MONTICELLO, LLC
Street Address 8131 N. MONTICELLO
City / State / Zip Code SKOKIE, ILLINOIS 60076
Phone Number (847) 262-3800
Fax Number (

	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	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 7,614	\$	35,676	\$ 258	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	13,676		35,676	463	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	25,960		35,676	879	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	17,828		35,676	604	4
5	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	33,024		35,676	1,118	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	24,903		35,676	843	6
7	34	RENT	ACTUAL CENSUS	1,053,513	34	9,100		35,676	308	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	11,640		35,676	394	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	38,500		35,676	1,304	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					\$ 182,245	\$		\$ 6,171	25

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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 CHASE OFFICE, LLC
Street Address 4655 W. CHASE AVE
City / State / Zip Code LINCOLNWOOD, IL 60712
Phone Number (847) 262-3800
Fax Number (

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 14,427	\$	35,676	\$ 489	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412		35,676	488	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076		35,676	206	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748		35,676	59	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201		35,676	108	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798		35,676	772	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544		35,676	222	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317		35,676	3,905	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973		35,676	1,218	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299		35,676	1,466	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821		35,676	434	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					\$ 276,616	\$		\$ 9,367	25

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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 ProPay HR LLC
Street Address 2201 W. MAIN ST
City / State / Zip Code EVANSTON , ILLINOIS 60202
Phone Number (847) 905 3268
Fax Number ()

	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	19	Payroll Services	Direct		\$	\$		\$ 16,536	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	TOTALS				\$	\$		\$ 16,536	25

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	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						\$	\$			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	TOTALS					\$	\$		\$	25

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	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						\$	\$			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	TOTALS					\$	\$		\$	25

Facility Name & ID Number Burgin Manor # 0054098 Report Period Beginning: 02/01/16 Ending: 12/31/16

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	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						\$	\$			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	TOTALS					\$	\$		\$	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							\$					\$	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	First Midwest Bank		X	Operating Line of Credit				961,287				16,606	6
7													7
8					-								8
9	TOTAL Facility Related						\$	961,287				\$ 16,606	9
	B. Non-Facility Related*												
10	Interest Income		X									(7)	10
11	Allocated from Aperion Care		X									4,948	11
12	Allocated Aperion Consulting		X									17	12
13	See Supplemental Schedule				-							2,061	13
14	TOTAL Non-Facility Related						\$					\$ 7,019	14
15	TOTALS (line 9+line14)						\$	961,287				\$ 23,625	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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 - SUPPLEMENTAL SCHEDULE

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							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15	Allocated 8131 N Monticello		X				\$					\$	84315
16	Allocated Chase Office, LLC		X										1,21816
17													17
18													18
19													19
20	TOTAL Non-Facility Related												2,06120

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	122,269	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.)			\$	116,420	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(5,849)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	113,650	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	107,801	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011	92,232	8		
	2012	92,143	9		
	2013	97,223	10		
	2014	102,460	11		
	2015	113,650	12		
2016 Accrual = 2016 Real Estate Tax Expense					
Allocated from 8131 N Monticello = \$1,304					
Allocated from Chase Office = \$1,466					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burgin Manor COUNTY Richland
FACILITY IDPH LICENSE NUMBER 0054098
CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-35-350-001</u>	<u>Long Term Care Property</u>	\$ <u>47,342.48</u>	\$ <u>47,342.48</u>
2. <u>06-35-350-002</u>	<u>Long Term Care Property</u>	\$ <u>66,307.52</u>	\$ <u>66,307.52</u>
3. <u>10-23-325-045-0000</u>	<u>Allocated from 8131 N. Monticello, I</u>	\$ <u>65,893.19</u>	\$ <u>1,137.56</u>
4. <u>10-27-307-027-0000</u>	<u>Allocated from Chase Office, LLC</u>	\$ <u>40,836.48</u>	\$ <u>578.09</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>220,379.67</u></u>	\$ <u><u>115,365.65</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? X YES 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation** . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Burgin Manor

COUNTY

Richland

FACILITY IDPH LICENSE NUMBER

0054098

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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).

None

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				\$	1
2	<u>Allocated from Chase Office, LLC</u>			<u>2,103</u>	2
3	TOTALS			\$ 2,103	3

HFS 3745 (N-4-99)

IL478-2471

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											4
5											5
6											6
7											7
8											8
	Improvement Type**										
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
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Burgin Manor

0054098

Report Period Beginning:

02/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									49
50									50
51									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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		116,254	3,511		2,979	(532)	9,815	68
69	Financial Statement Depreciation			10,525			(10,525)		69
70	TOTAL (lines 4 thru 69)		\$ 116,254	\$ 14,036		\$ 2,979	\$ (11,057)	\$ 9,815	70

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

Facility Name & ID Number Burgin Manor

0054098

Report Period Beginning:

02/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 116,254	\$ 14,036		\$ 2,979	\$ (11,057)	\$ 9,815	1
2	Security Alarm	2016	48,093		20	1,002	1,002	1,002	2
3	Carpet-Material And Labor Cost To Carpet The East Building (E	2016	2,723		20	34	34	34	3
4	Project Coordination Door Floor: Digital Prints For All Exterior I	2016	5,958		20	31	31	31	4
5	Sewer Pipe**	2016	55,131		20	289	289	289	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 228,160	\$ 14,036		\$ 4,335	\$ (9,701)	\$ 11,171	34

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

Facility Name & ID Number Burgin Manor

0054098

Report Period Beginning:

02/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 228,160	\$ 14,036		\$ 4,335	\$ (9,701)	\$ 11,171	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 228,160	\$ 14,036		\$ 4,335	\$ (9,701)	\$ 11,171	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 228,160	\$ 14,036		\$ 4,335	\$ (9,701)	\$ 11,171	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 228,160	\$ 14,036		\$ 4,335	\$ (9,701)	\$ 11,171	34

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

Facility Name & ID Number Burgin Manor

0054098

Report Period Beginning:

02/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 228,160	\$ 14,036		\$ 4,335	\$ (9,701)	\$ 11,171	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 228,160	\$ 14,036		\$ 4,335	\$ (9,701)	\$ 11,171	34

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

Facility Name & ID Number Burgin Manor

0054098

Report Period Beginning:

02/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Burgin Manor

0054098

Report Period Beginning:

02/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Burgin Manor

0054098

Report Period Beginning:

02/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Chase Office, LLC	2016	18,924	202	35	202		202	3
4	Allocated from 8131 N Monticello	2010		403	35	350	(53)	3,628	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Chase Office, LLC	2016	95,913	1,998	20	1,998		1,998	9
10									10
11	Allocated from Aperion Care	2010	1,009	162	20	50	(112)	353	11
12	Allocated from Aperion Care	2012	286	22	20	14	(8)	72	12
13	Allocated from Aperion Care	2013	122	14	20	6	(8)	24	13
14									14
15	Allocated from 8131 N Monticello	2010		710	20	306	(404)	3,211	15
16	Allocated from 8131 N Monticello	2013			20	53	53	327	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	TOTAL (lines 1 thru 33)		\$ 116,254	\$ 3,511		\$ 2,979	\$ (532)	\$ 9,815	34

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

Facility Name & ID Number Burgin Manor

0054098

Report Period Beginning:

02/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 116,254	\$ 3,511		\$ 2,979	\$ (532)	\$ 9,815	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 116,254	\$ 3,511		\$ 2,979	\$ (532)	\$ 9,815	34

**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	\$ 3,912	\$ 691	\$ 459	\$ (232)	10	\$ 1,125	71
72	Current Year Purchases	57,201	2,132	2,390	258	10	2,390	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 61,113	\$ 2,823	\$ 2,849	\$ 26		\$ 3,515	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		Grand Caravan 2015	2016	\$ 33,199	\$	\$ 6,086	\$ 6,086	5	\$ 6,086	76
77		Allocated from Aperion Care	2016	1,333	230	227	(3)	5	509	77
78		Allocated from Aperion Consulti	2016	785	152	157	5	5	314	78
79										79
80	TOTALS			\$ 35,317	\$ 382	\$ 6,470	\$ 6,088		\$ 6,909	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)	\$ 326,693	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,241	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 13,655	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,586)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 21,596	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	\$ 138,436	92
93			93
94			94
95		\$ 138,436	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:OLNEY PROPERTY HOLDINGS, LLC,
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐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:		157		\$498,000			3
4	Additions							4
5	Allocated from Aperion Care				608			5
6								6
7	TOTAL		157		\$498,608			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:\$3,028Description:See Attached Schedule

(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		Chrysler Capital	\$481	\$481	17
18	Allocated from Aperion Consulting			413	18
19					19
20					20
21	TOTAL		\$481	\$894	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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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

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	39 - 03	hrs	\$		\$ 165,755	\$		\$ 165,755	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			80,989			80,989	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			181,604			181,604	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				104,362		104,362	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					4,839	27,885		32,724	13
14	TOTAL			\$		\$ 433,187	\$ 132,247		\$ 565,434	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	\$		1
2	Cash-Patient Deposits		500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,392,748	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		88,056	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>		74,924	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	1,556,228	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost		132,205	15
16	Equipment, at Historical Cost		52,757	16
17	Accumulated Depreciation (book methods)		(10,525)	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>See Attached Schedule</u>		634,672	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	809,109	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	2,365,337	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	718,937	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		961,287	29
30	Accrued Salaries Payable		242,428	30
31	Accrued Taxes Payable (excluding real estate taxes)		9,267	31
32	Accrued Real Estate Taxes(Sch.IX-B)		113,650	32
33	Accrued Interest Payable		3,352	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	2,048,921	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>		1,137,688	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	1,137,688	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	3,186,609	46
47	TOTAL EQUITY(page 18, line 24)	\$	(821,272)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	2,365,337	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(821,272)	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)	\$ (821,272)	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)	\$ (821,272)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Burgin Manor

0054098

Report Period Beginning: 02/01/16

Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,603,518	1
2	Discounts and Allowances for all Levels	406,796	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,010,314	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	142,623	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 142,623	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	94,602	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,304	19
20	Radiology and X-Ray	12,386	20
21	Other Medical Services	19,306	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 141,598	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	543	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 543	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,295,085	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,188,061	31
32	Health Care	2,638,082	32
33	General Administration	1,731,164	33
	B. Capital Expense		
34	Ownership	660,447	34
	C. Ancillary Expense		
35	Special Cost Centers	602,367	35
36	Provider Participation Fee	296,236	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,116,357	40
41	Income before Income Taxes (line 30 minus line 40)**	(821,272)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (821,272)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,486,018	44
45	Private Pay - Net Inpatient Revenue	2,193,896	45
46	Medicare - Net Inpatient Revenue	1,115,205	46
47	Other-(specify) Insurance & Managed Care	215,195	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,010,314	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** 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	1,728	1,810	\$ 62,419	\$ 34.49	1
2	Assistant Director of Nursing	1,555	1,842	45,231	24.56	2
3	Registered Nurses	20,949	25,039	587,340	23.46	3
4	Licensed Practical Nurses	19,333	20,806	431,002	20.72	4
5	CNAs & Orderlies	70,667	77,208	909,352	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,837	4,242	66,282	15.63	8
9	Activity Director	2,250	1,823	32,478	17.82	9
10	Activity Assistants	10,655	2,806	114,188	40.69	10
11	Social Service Workers	4,752	4,900	107,736	21.99	11
12	Dietician					12
13	Food Service Supervisor	1,709	2,076	31,456	15.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,356	22,793	220,605	9.68	15
16	Dishwashers					16
17	Maintenance Workers	3,612	3,794	77,125	20.33	17
18	Housekeepers	15,084	16,185	168,505	10.41	18
19	Laundry	7,593	8,317	78,148	9.40	19
20	Administrator	1,592	1,822	86,711	47.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,805	1,961	58,389	29.78	23
24	Clerical	4,478	4,900	105,498	21.53	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	827	891	22,050	24.75	31
32	Other Health Care(specify)					32
33	Other(specify)	3,057	3,288	32,647	9.93	33
34	TOTAL (lines 1 - 33)	196,839	206,503	\$ 3,237,162 *	\$ 15.68	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	250	\$ 13,825	01-03	35
36	Medical Director	Monthly	6,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	44,800	10-03	38
39	Pharmacist Consultant	Monthly	2,130	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	51	3,933	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	301	\$ 71,288		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.

STATE OF ILLINOIS

Facility Name & ID Number

Burgin Manor

0054098

Report Period Beginning:

02/01/16

Ending:

12/31/16

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description			Amount	Description		Amount	
STACY BLUE (2/1/16 - 3/26/16)		Administrator	0	\$ 24,509	Workers' Compensation Insurance		\$	75,853	IDPH License Fee		\$	
BROOKE SEESGOOD (5/4/16 - 12/31/16)		Administrator	0	62,202	Unemployment Compensation Insurance			78,563	Advertising: Employee Recruitment		5,278	
					FICA Taxes			245,145	Health Care Worker Background Check			
					Employee Health Insurance			143,370	(Indicate # of checks performed 115)		1,150	
					Employee Meals				Patient Background Checks		490	
					Illinois Municipal Retirement Fund (IMRF)*				License and Permits		9,331	
					Employee Benefits - Other			6,867	Dues and Subscriptions		14,951	
					Employee Physicals			1,040	Allocated from Aperion Care		5,242	
					Employee Meals			849	Allocated from Aperion Consulting		1,508	
TOTAL (agree to Schedule V, line 17, col. 1)												
(List each licensed administrator separately.)				\$ 86,711								
B. Administrative - Other												
Description				Amount								
Management Fees- Aperion Care				\$ 271,182					Less: Public Relations Expense		()	
									Non-allowable advertising		()	
									Yellow page advertising		()	
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 551,687		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 38,379	
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 271,182	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
(Attach a copy of any management service agreement)												
C. Professional Services												
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount	
Aperion Care		Data Processing		\$ 15,199				\$	Out-of-State Travel		\$	
Creative Technology Solutions		Data Processing		11,985								
Wescom Solutions		Data Processing		22,138								
National Datacare Corporation		Data Processing		2,419					In-State Travel			
Ability Network INC		Data Processing		4,075								
PointClick Care Technologies INC		Data Processing		11,731								
Aperion Care		Home Office Expense		94,334					Seminar Expense		7,358	
Aperion Financial		Home Office Expense		77,519					Allocated from Aperion Care		1,632	
									Allocated from Aperion Consulting		1,055	
									See Supplemental Schedule		46	
									Entertainment Expense		()	
Propay HR		Payroll Processing		21,758					(agree to Sch. V, line 24, col. 8)			
See Supplemental Schedule				5,869					TOTAL		\$ 10,091	
TOTAL (agree to Schedule V, line 19, column 3)				\$ 267,027	TOTAL				\$			
(For legal fee disclosure, see page 39 of instructions)												

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Burgin Manor	STATE OF ILLINOIS # 0054098	Report Period Beginning: 02/01/16	Ending: 12/31/16
--	--	---	--------------------------------

Page 22

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. ICLTC \$5,000

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
 What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,471 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 296,236
 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 benefit on Schedule V. \$ NO Has any meal income been offset against related costs? NO Indicate the amount. \$ _____

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
 Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
 Attach invoices and a summary of services for all architect and appraisal fees