FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0026765

Facility Name: BURGIN MANOR OF OLNEY, INC.

Address: 900 EAST SCOTT STREET (Number) OLNEY (City) 62450 (Zip Code)

County: RICHLAND

Telephone Number: (618) 395-2150 **Fax #** (618) 392-2150

HFS ID Number:

Date of Initial License for Current Owners: 4/20/1982

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: KEN MARX **Telephone Number:** (314) 231-5544
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) KEN MARX, PARTNER
(Firm Name & Address) BKD, LLP, 211 N BROADWAY, STE 600 ST. LOUIS MO, 63102
(Telephone) (314) 231-5544 Fax # (314) 231-9731

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	157	Skilled (SNF)	157	57,305	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	157	TOTALS	157	57,305	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,502	16,625	5,031	52,158	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,502	16,625	5,031	52,158	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.02%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/20/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/20/1982 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 157 and days of care provided 5,031

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	372,338	20,999	15,180	408,517		408,517		408,517			1
2	Food Purchase		339,712		339,712		339,712	(3,866)	335,846			2
3	Housekeeping	170,735	28,838		199,573		199,573		199,573			3
4	Laundry	134,589	12,320	5,645	152,554		152,554		152,554			4
5	Heat and Other Utilities			160,965	160,965		160,965		160,965			5
6	Maintenance	77,519	15,716	132,608	225,843		225,843		225,843			6
7	Other (specify):*											7
8	TOTAL General Services	755,181	417,585	314,398	1,487,164		1,487,164	(3,866)	1,483,298			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,839,334	218,359	253,681	3,311,374		3,311,374		3,311,374			10
10a	Therapy		3,346	503,190	506,536		506,536		506,536			10a
11	Activities											11
12	Social Services	204,701	5,092	7,857	217,650		217,650		217,650			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,044,035	226,797	771,928	4,042,760		4,042,760		4,042,760			16
	C. General Administration											
17	Administrative	112,017		192,000	304,017		304,017	(19,493)	284,524			17
18	Directors Fees											18
19	Professional Services			24,697	24,697		24,697		24,697			19
20	Dues, Fees, Subscriptions & Promotions			17,199	17,199		17,199	(490)	16,709			20
21	Clerical & General Office Expenses	105,811	23,905	53,575	183,291		183,291	(18,812)	164,479			21
22	Employee Benefits & Payroll Taxes			905,162	905,162		905,162		905,162			22
23	Inservice Training & Education			529	529		529		529			23
24	Travel and Seminar			5,017	5,017		5,017		5,017			24
25	Other Admin. Staff Transportation			21,355	21,355		21,355		21,355			25
26	Insurance-Prop.Liab.Malpractice			73,817	73,817		73,817		73,817			26
27	Other (specify):*											27
28	TOTAL General Administration	217,828	23,905	1,293,351	1,535,084		1,535,084	(38,795)	1,496,289			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,017,044	668,287	2,379,677	7,065,008		7,065,008	(42,661)	7,022,347			29

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

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

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. #0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			84,100	84,100		84,100		84,100			30
31	Amortization of Pre-Op. & Org.			4,946	4,946		4,946		4,946			31
32	Interest			168,425	168,425		168,425	(13,617)	154,808			32
33	Real Estate Taxes			92,205	92,205		92,205		92,205			33
34	Rent-Facility & Grounds							11,050	11,050			34
35	Rent-Equipment & Vehicles			34,574	34,574		34,574		34,574			35
36	Other (specify):*											36
37	TOTAL Ownership			384,250	384,250		384,250	(2,567)	381,683			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,278		18,278		18,278		18,278			39
40	Barber and Beauty Shops			20,672	20,672		20,672		20,672			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,958	85,958		85,958		85,958			42
43	Other (specify):* NON ALLOWABLE			97,588	97,588		97,588	(91,868)	5,720			43
44	TOTAL Special Cost Centers		18,278	204,218	222,496		222,496	(91,868)	130,628			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,017,044	686,565	2,968,145	7,671,754		7,671,754	(137,096)	7,534,658			45

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

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,866)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,298)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13,617)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(27,540)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(18,060)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,920)	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	(39,224)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (135,525)		$	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)	(1,571)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,571)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (137,096)		37

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

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

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

BURGIN MANOR OF OLNEY, INC.

ID# 0026765

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING MACHINE EXPENSE	$ (8,129)	43	1
2	LOBBYING	(816)	20	2
3	NEWSCOOP	(5,170)	43	3
4	TRANSFER INSURANCE	(10,608)	43	4
5	PUBLIC RELATIONS	(2,571)	43	5
6	GOLDEN FRIENDSHIP	(363)	43	6
7	RESIDENT/ FAMILY RELATIONS	(3,668)	43	7
8	CORPORATE TAXES	(7,899)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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**	(39,224)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,866)	0	0	0	0	0	0	0	0	0	0	(3,866)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,866)	0	0	0	0	0	0	0	0	0	0	(3,866)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(19,493)	0	0	0	0	0	0	0	0	0	(19,493)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(816)	326	0	0	0	0	0	0	0	0	0	(490)	20
21	Clerical & General Office Expenses	(25,358)	6,546	0	0	0	0	0	0	0	0	0	(18,812)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(26,174)	(12,621)	0	0	0	0	0	0	0	0	0	(38,795)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,040)	(12,621)	0	0	0	0	0	0	0	0	0	(42,661)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,617)	0	0	0	0	0	0	0	0	0	0	(13,617)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	11,050	0	0	0	0	0	0	0	0	0	11,050	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,617)	11,050	0	0	0	0	0	0	0	0	0	(2,567)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(91,868)	0	0	0	0	0	0	0	0	0	0	(91,868)	43
44	**TOTAL Special Cost Centers**	(91,868)	0	0	0	0	0	0	0	0	0	0	(91,868)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(135,525)	(1,571)	0	0	0	0	0	0	0	0	0	(137,096)	45

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 192,000			$ 172,507	$ (19,493)	1
2	V	21	TAXES & LICENSES				377	377	2
3	V	21	CLERICAL EXPENSES				6,169	6,169	3
4	V	34	RENT				11,050	11,050	4
5	V	20	DUES & SUBSCRIPTIONS				326	326	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			$ 192,000			$ 190,429	$ * (1,571)	14

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

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [x] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	MGMT FEES	DIRECT COSTS	1		$	$ 172,507	1	$ 0	1
2	21	TAXES & LICENSES	DIRECT COSTS	1			377	1	0	2
3	21	CLERICAL EXPENSES	DIRECT COSTS	1			6,169	1	0	3
4	34	RENT	DIRECT COSTS	1			11,050	1	0	4
5	20	DUES & SUBSCRIPTIONS	DIRECT COSTS	1			326	1	0	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					$	$ 190,429		$	25

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HEARTLAND BANK		X	MORTGAGE	5 YRS @ 6.49%	10/4/07	$ 2,343,158	$ 2,297,006	10/4/12	0.0649	$ 152,774	1
2	CHASE AUTO FINANCE		X	2003 AUDI	5 YRS @ 6.49%	4/28/09	10,387	2,700	4/28/11	0.0649	545	2
3	FIRST NATIONAL BANK		X	2006 CHEVY	4 YRS @ 6.25%	2/19/09	16,271	11,476	2/19/13	0.0625	905	3
4												4
5												5
	Working Capital											
6	HEARTLAND BANK		X	OPERATING	1 YR VARIABL	10/4/09	600,673		10/4/10	VARIABLE	12,677	6
7	VARIOUS		X	VARIOUS	VARIOUS	VAREOPIS			VARIOUS	VARIOUS	1,524	7
8												8
9	TOTAL Facility Related						$ 2,970,489	$ 2,311,182			$ 168,425	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,970,489	$ 2,311,182			$ 168,425	15

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

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

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

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 87,125	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.)		$ 89,665	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,540	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 89,665	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 92,205	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	75,789	8
	2006	80,199	9
	2007	80,464	10
	2008	83,440	11
	2009	87,125	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BURGIN MANOR OF OLNEY, INC. COUNTY RICHLAND

FACILITY IDPH LICENSE NUMBER 0026765

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1-0635-350-001	SEE ATTACHED	$ 34,750.86	$ 34,750.86
2.	1-0635-350-002	SEE ATTACHED	$ 54,914.12	$ 54,914.12
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 89,664.98	$ 89,664.98

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1982	1982	$ 1,510,000	$	15	$	$	$ 1,510,000	4
5			1996	1996	826,743	21,199	39	21,199		309,946	5
6											6
7											7
8											8
	Improvement Type**										
9	1986Additions			1986	24,917		Various			24,917	9
10	1989 Additions			1989	10,163		Various			10,163	10
11	1990 Additions			1990	12,277		Various			12,277	11
12	1991 Additions			1991	28,943	919	Various	919		18,070	12
13	1992 Additions			1992	7,925	252	Various	252		4,569	13
14	1993 Additions			1993	45,898	1,258	Various	1,258		23,398	14
15	1994 Additions			1994	32,737	567	Various	567		19,928	15
16	1995 Additions			1995	2,846	73	Various	73		1,113	16
17	1996 Additions			1996	20,883	262	Various	262		20,752	17
18	1997 Additions			1997	30,726		Various			30,726	18
19	1998 Additions			1998	30,205	775	Various	775		9,723	19
20	1999 Additions			1999	1,752	45	Various	45		525	20
21	2001 Additions			2001	15,512	564	Various	564		5,478	21
22	2002 Additions			2002	255	9	Various	9		75	22
23	2003 Additions			2003	50,767	1,802	Various	1,802		14,698	23
24	2004 Addtitions			2004	68,612	2,429	Various	2,429		17,261	24
25	2005 Additions			2005	1,119	41	Various	41		219	25
26	2006 Additions			2006	27,893	1,014	Various	1,014		4,777	26
27	New Flooring For W Bldg Dinning Room			2007	5,100	185	27	185		641	27
28	Replacement Faucets for W Bldg			2007	1,995	73	27	73		239	28
29	W Bldg Main Swer Line in Basement			2007	8,434	307	27	307		958	29
30	Sprinkler System in E Bldg			2008	1,284	47	27	47		134	30
31	New Water Heater in EE Boiler			2008	1,764	64	27	64		142	31
32	LASCO Ada Shower			2008	1,514	54	27	54		112	32
33	Sprinklers			2010	21,859	629	27	629		629	33
34	New Kitchen Flooring			2010	3,427	36	27	36		36	34
35	AC for East Dining Area			2010	12,294	316	27	316		317	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 OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	1991 Additions	1991	$ 622	$	Various	$	$	$ 622	37
38	1992 Additions	1992	1,112		Various			1,112	38
39	1995 Additions	1995	455		Various			455	39
40	1996 Additions	1996	1,533		Various			1,473	40
41	1997 Additions	1997	10,748	624	Various	624		9,812	41
42	1998 Additions	1998	40,413	2,347	Various	2,347		34,547	42
43	1999 Additions	1999	29,814	1,775	Various	1,775		23,603	43
44	2000 Additions	2000	906	53	Various	53		665	44
45	2006 Additions	2006	11,300	782	Various	782		4,257	45
46	Patio East Parking Lot	2008	5,113	219	15	219		3,146	46
47	East Parking Lot	2009	24,988	1,187	15	1,187		14,306	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,934,848	$ 39,907		$ 39,907	$	$ 2,135,821	70

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

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 238,901	$ 2,387	$ 2,387	$	Various	$ 225,335	71
72	Current Year Purchases		37,142	37,142		Various	37,142	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 238,901	$ 39,529	$ 39,529	$		$ 262,477	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FORD RANGER	92 FORD RANGER	1996	$ 3,780	$	$	$	5	$ 3,780	76
77	FORD VAN	2000 FORD VAN	2000	42,810	1,775	1,775		5	25,110	77
78										78
79	FACILITY USE	SEE SCHEDULE F BELOW	Various	78,460	2,889	2,889		5	59,564	79
80	TOTALS			$ 125,050	$ 4,664	$ 4,664	$		$ 88,454	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,373,799	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 84,100	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 84,100	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,486,752	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2004 TOYOTA CAMRY	$ 24,399	$ 1,114	$ 24,339	86
87	2003 AUDI	32,996	1,775	14,160	87
88	CHEVY VAN WITH LIFT	21,065		21,065	88
89					89
90					90
91	TOTALS	$ 78,460	$ 2,889	$ 59,564	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 26,583 Description: IVAC PUMPS, SPECIALITY BEDS, OXYGEN CONCENTRATORS, MISC
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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.

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	3,202	$ 207,390	$	3,202	$ 207,390	1
2	Licensed Speech and Language Development Therapist		hrs		829	63,244		829	63,244	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,698	232,556		3,698	232,556	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	7,729	$ 503,190	$	7,729	$ 503,190	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.

STATE OF ILLINOIS

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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	$ 445,307	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	351,149		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,652		6
7	Other Prepaid Expenses	55,934		7
8	Accounts Receivable (owners or related parties)	220,114		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,079,156	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,000		13
14	Buildings, at Historical Cost	3,225,985		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	387,534		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,489,843)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LOAN COSTS	341,493		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,540,169	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,619,325	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 158,738	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,700		29
30	Accrued Salaries Payable	81,993		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	89,665		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER MISCELLANEOUS LIABILITIE	40,074		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 373,170	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	13,830		39
40	Mortgage Payable	2,297,006		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,310,836	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,684,006	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (64,681)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,619,325	$	48

***(See instructions.)**

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (235,234)	1
2	Restatements (describe):	36,833	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (198,401)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	133,720	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)**	$ 133,720	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)**	$ (64,681)	24 *

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

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,190,354	1
2	Discounts and Allowances for all Levels	(506,071)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,684,283	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	591,662	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 591,662	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,463	13
14	Non-Patient Meals	3,866	14
15	Telephone, Television and Radio	11,837	15
16	Rental of Facility Space		16
17	Sale of Drugs	202,113	17
18	Sale of Supplies to Non-Patients	223,830	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 464,109	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,617	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,617	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER MISCELLANEOUS INCOME	51,803	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,803	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,805,474	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,487,164	31
32	Health Care	4,042,760	32
33	General Administration	1,535,084	33
	B. Capital Expense		
34	Ownership	384,250	34
	C. Ancillary Expense		
35	Special Cost Centers	136,538	35
36	Provider Participation Fee	85,958	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,671,754	40
41	**Income before Income Taxes (line 30 minus line 40)****	133,720	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 133,720	43

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

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,085	2,317	$ 73,704	$ 31.81	1
2	Assistant Director of Nursing	2,085	2,301	51,909	22.56	2
3	Registered Nurses	32,728	35,767	699,553	19.56	3
4	Licensed Practical Nurses	29,192	30,510	505,870	16.58	4
5	CNAs & Orderlies	124,925	130,119	1,345,036	10.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,181	2,301	33,219	14.44	9
10	Activity Assistants	17,034	17,500	151,274	8.64	10
11	Social Service Workers	1,734	1,825	20,209	11.07	11
12	Dietician					12
13	Food Service Supervisor	2,085	2,325	45,944	19.76	13
14	Head Cook	7,484	7,707	73,769	9.57	14
15	Cook Helpers/Assistants	22,328	22,893	194,768	8.51	15
16	Dishwashers					16
17	Maintenance Workers	5,740	5,921	77,519	13.09	17
18	Housekeepers	17,540	18,520	170,735	9.22	18
19	Laundry	14,624	15,195	134,588	8.86	19
20	Administrator	2,085	2,285	78,445	34.33	20
21	Assistant Administrator	1,529	1,669	33,572	20.12	21
22	Other Administrative					22
23	Office Manager	2,088	2,346	51,650	22.02	23
24	Clerical	3,605	3,821	54,161	14.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS Cord	8,109	8,779	163,262	18.60	32
33	Other(specify) Dietary Nut	6,813	6,936	57,858	8.34	33
34	TOTAL (lines 1 - 33)	305,994	321,037	$ 4,017,045 *	$ 12.51	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	198	$ 11,492	LINE 1 (3)	35
36	Medical Director		7,200	LINE 9 (3)	36
37	Medical Records Consultant		1,180	LINE 10 (3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,945	LINE 10 (3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	1,991	LINE 11 (3)	44
45	Social Service Consultant	26	1,953	LINE 12 (3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	251	$ 34,761		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUE E BURGIN	ADMINISTRATOR		$ 78,445
OTHER			33,572
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 112,017

B. Administrative - Other

Description	Amount
BURGIN HEALTH MANAGEMENT	$ 192,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 192,000

C. Professional Services

Vendor/Payee	Type	Amount
CUNNINGHAM ACCOUNTING	ACCOUNTING	$ 9,934
STONE CARLIE	ACCOUNTING	6,200
BKD, LLP	ACCOUNTING	6,200
ROSENBLUM, GOLDENHERSH, S	LEGAL	2,363
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 24,697

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	677,180
Employee Health Insurance	182,900
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 K MATCH	37,395
OTHER BENEFITS	7,687
TOTAL (agree to Schedule V, line 22, col.8)	$ 905,162

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	787
Recruitment	1,038
Liscense Fee	1,990
Subscriptions	2,609
Dues	10,775
Less: Public Relations Expense	( )
Non-allowable advertising	(490)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,709

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,017
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,017

**See instructions.

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

Facility Name & ID Number BURGIN MANOR OF OLNEY, INC. # 0026765 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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. **IHAC $9,388.60**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **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? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,918** Line **No**

(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 **C** 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. $ **85,958**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **3,866**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **14,984**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.