		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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0026765

Facility Name: BURGIN MANOR OF OLNEY INC

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

County: RICHLAND

Telephone Number: (618) 395-1000 Fax # (618) 392-2150

HFS ID Number:

Date of Initial License for Current Owners: 04/20/1982

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2015 to 12/31/2015 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)	PATRICIA RACHELL DIRECTOR
	(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

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

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	21,993	17,110	5,941	45,044	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,993	17,110	5,941	45,044	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.60%

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)
____

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 4,445

Medicare Intermediary WPS, INC.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	416,215	20,961	17,346	454,522		454,522		454,522			1
2	Food Purchase		398,386		398,386		398,386	(5,347)	393,039			2
3	Housekeeping	195,886	31,961	3,041	230,888		230,888		230,888			3
4	Laundry	192,512	43,901	1,039	237,452		237,452		237,452			4
5	Heat and Other Utilities			147,451	147,451		147,451		147,451			5
6	Maintenance	76,076	97,664	170,633	344,373		344,373		344,373			6
7	Other (specify):*											7
8	TOTAL General Services	880,689	592,873	339,510	1,813,072		1,813,072	(5,347)	1,807,725			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,656,556	156,344	8,198	2,821,098		2,821,098		2,821,098			10
10a	Therapy		830	763,081	763,911		763,911		763,911			10a
11	Activities	176,613	5,567	2,139	184,319		184,319		184,319			11
12	Social Services	112,892	867	5,246	119,005		119,005		119,005			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,946,061	163,608	785,864	3,895,533		3,895,533		3,895,533			16
	C. General Administration											
17	Administrative	130,875		226,000	356,875		356,875	10,504	367,379			17
18	Directors Fees											18
19	Professional Services			62,326	62,326		62,326		62,326			19
20	Dues, Fees, Subscriptions & Promotions			19,206	19,206		19,206	(754)	18,452			20
21	Clerical & General Office Expenses	214,708	19,453	63,038	297,199		297,199	(12,227)	284,972			21
22	Employee Benefits & Payroll Taxes			868,671	868,671		868,671	(16,463)	852,208			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,542	11,542		11,542		11,542			24
25	Other Admin. Staff Transportation			15,316	15,316		15,316		15,316			25
26	Insurance-Prop.Liab.Malpractice			75,416	75,416		75,416		75,416			26
27	Other (specify):*											27
28	TOTAL General Administration	345,583	19,453	1,341,515	1,706,551		1,706,551	(18,940)	1,687,611			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,172,333	775,934	2,466,889	7,415,156		7,415,156	(24,287)	7,390,869			29

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

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

Facility Name & ID Number BURGIN MANOR OF OLNEY INC #0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			93,770	93,770	3,740	97,510	102	97,612			30
31	Amortization of Pre-Op. & Org.			3,740	3,740	(3,740)						31
32	Interest			118,457	118,457		118,457	(5,260)	113,197			32
33	Real Estate Taxes			115,141	115,141		115,141		115,141			33
34	Rent-Facility & Grounds							7,800	7,800			34
35	Rent-Equipment & Vehicles			33,124	33,124		33,124		33,124			35
36	Other (specify):*											36
37	**TOTAL Ownership**			364,232	364,232		364,232	2,642	366,874			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		221,571	59,638	281,209		281,209		281,209			39
40	Barber and Beauty Shops			21,951	21,951		21,951		21,951			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			332,375	332,375		332,375		332,375			42
43	Other (specify):* NONALLOWABLE			108,413	108,413		108,413	(110,219)	(1,806)			43
44	**TOTAL Special Cost Centers**		221,571	522,377	743,948		743,948	(110,219)	633,729			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,172,333	997,505	3,353,498	8,523,336		8,523,336	(131,864)	8,391,472			45

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

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Reference	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	(2,067)	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	(5,260)	32		10
11	Discounts, Allowances, Rebates & Refunds	(5,347)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25,579)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(16,463)	22		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,000)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(48,430)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(278)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(36,846)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (150,270)		$	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)	18,407		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 18,407		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (131,863)		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		N	21,951	40	41
42	Laboratory and Radiology		N	59,638	39	42
43	Prescription Drugs		N	163,570	39	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 245,159		47

STATE OF ILLINOIS

BURGIN MANOR OF OLNEY INC

ID# 0026765

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	CABLE TV EXPENSES	$ (5,239)	43	1
2	VENDING MACHINE EXPENSES	(4,752)	43	2
3	LOBBYING EXPENSES	(754)	20	3
4	NEWSCOOP	(4,750)	43	4
5	PUBLIC RELATIONS	(9,244)	43	5
6	RESIDENT/FAMILY RELATIONS	(10,124)	43	6
7	MARKETING SUPPLIES	(1,823)	43	7
8	RESIDENT PURCHASES	(160)	21	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**	(36,846)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,347)	0	0	0	0	0	0	0	0	0	0	(5,347)	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**	(5,347)	0	0	0	0	0	0	0	0	0	0	(5,347)	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	10,504	0	0	0	0	0	0	0	0	0	10,504	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(754)	0	0	0	0	0	0	0	0	0	0	(754)	20
21	Clerical & General Office Expenses	(12,227)	0	0	0	0	0	0	0	0	0	0	(12,227)	21
22	Employee Benefits & Payroll Taxes	(16,463)	0	0	0	0	0	0	0	0	0	0	(16,463)	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**	(29,444)	10,504	0	0	0	0	0	0	0	0	0	(18,940)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,791)	10,504	0	0	0	0	0	0	0	0	0	(24,287)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	102	0	0	0	0	0	0	0	0	0	102	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,260)	0	0	0	0	0	0	0	0	0	0	(5,260)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	7,800	0	0	0	0	0	0	0	0	0	7,800	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	(5,260)	7,902	0	0	0	0	0	0	0	0	0	2,642	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):*	(110,219)	0	0	0	0	0	0	0	0	0	0	(110,219)	43
44	TOTAL Special Cost Centers	(110,219)	0	0	0	0	0	0	0	0	0	0	(110,219)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(150,270)	18,406	0	0	0	0	0	0	0	0	0	(131,864)	45

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SHIRLEY AXELBAUM	61.12			BURGIN MANOR M(	UNIVERSITY CITY	MANAGEMENT C(
BRUCE AXELBAUM	18.43			BURGIN MANOR M(	UNIVERSITY CITY	MANAGEMENT C(
RICHARD AXELBAUM	9.72			BURGIN MANOR M(	UNIVERSITY CITY	MANAGEMENT C(
STEVEN AXELBAUM	1.01			BURGIN MANOR M(	UNIVERSITY CITY	MANAGEMENT C(
DAVID AXELBAUM	5.32			BURGIN MANOR M(	UNIVERSITY CITY	MANAGEMENT C(
DAVID AXELBAUM TRUST	4.4			BURGIN MANOR 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	$ 226,000			$ 236,504	$ 10,504	1
2	V	34	RENT				7,800	7,800	2
3	V	30	DEPRECIATION				102	102	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			$ 226,000			$ 244,406	$ * 18,406	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: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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25								25
26								26
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28								28
29								29
30								30

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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 [ ]

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

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

	1 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	MANAGEMENT FEES	DIRECT COSTS	1		$	$ 0	1	$ 0	1
2	34	RENT	DIRECT COSTS	1			0	1	0	2
3	30	DEPRECIATION	DIRECT COSTS	1			0	1	0	3
4										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 OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	JEFFERSON BANK & TRUST		X	MORTGAGE	5yrs @ 3.5%	07/10/14	$ 3,000,000	$ 2,849,476	07/10/19	0.0350	$ 101,765	1
2	CHASE AUTO FINANCE		X	2013 CAMRY	5yrs @ 3.74%	12/18/13	28,664	17,847	12/18/18	0.0374	793	2
3	CHRYSLER CAPITAL		X	2015 GRAND CARAVAN	6yrs @ 0.00%	09/24/15	34,642	33,680	09/24/21			3
4												4
5												5
	Working Capital											
6	JEFFERSON BANK & TRUST		X	OPERATING LINE OF CRED	1yr @ 3.75%	07/10/15	330,687	545,000	07/10/15	0.0375	14,480	6
7												7
8												8
9	TOTAL Facility Related						$ 3,393,993	$ 3,446,003			$ 117,038	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,393,993	$ 3,446,003			$ 117,038	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE Line # ______

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

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

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2014 report.	$	102,460	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.)	$	108,800	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,340	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	108,800	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.	$	115,140	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	89,666	8
	2011	92,232	9
	2012	92,143	10
	2013	97,223	11
	2014	102,460	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-35-350-001	SEE ATTACHED	$ 45,322.30	$ 45,322.30
2.	06-35-350-002	SEE ATTACHED	$ 63,478.10	$ 63,478.10
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 108,800.40	$ 108,800.40

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ________ YES X________ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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? [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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	RESIDENT CARE	234,725	1982	$ 75,000	1
2					2
3	TOTALS	234,725		$ 75,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	30,063	39	30,063		589,875	5
6			2014		(218,160)					(218,160)	6
7											7
8											8
	Improvement Type**										
9	1986 ADDITIONS			1986	24,917		VARIOUS			24,917	9
10	1989 ADDITIONS			1989	10,163		VARIOUS			10,163	10
11	1990 ADDITIONS			1990	12,277		VARIOUS			12,277	11
12	1991 ADDITIONS			1991	28,943	919	VARIOUS	919		22,665	12
13	1992 ADDITIONS			1992			VARIOUS				13
14	1993 ADDITIONS			1993	14,085	447	VARIOUS	447		10,154	14
15	1994 ADDITIONS			1994	28,830	495	VARIOUS	495		20,153	15
16	1995 ADDITIONS			1995			VARIOUS				16
17	1996 ADDITIONS			1996			VARIOUS				17
18	1997 ADDITIONS			1997			VARIOUS				18
19	1998 ADDITIONS			1998	26,749	686	VARIOUS	686		12,037	19
20	1999 ADDITIONS			1999			VARIOUS				20
21	2001 ADDITIONS			2001	12,131	441	VARIOUS	441		6,488	21
22	2002 ADDITIONS			2002			VARIOUS				22
23	2003 ADDITIONS			2003	49,548	1,802	VARIOUS	1,802		22,488	23
24	2004 ADDITIONS			2004	62,588	2,276	VARIOUS	2,276		25,845	24
25	2005 ADDITIONS			2005			VARIOUS				25
26	2006 ADDITIONS			2006	27,893	1,014	VARIOUS	1,014		9,849	26
27	NEW FLOORING FOR W BLDG DINING ROOM			2007			27				27
28	REPLACEMENT FAUCETS FOR W BLDG			2007			27				28
29	W BLDG MAIN SEWER LINE IN BASEMENT			2007	8,434	307	27	307		2,492	29
30	SPRINKLER SYSTEM IN E BLDG			2008			27				30
31	NEW WATER HEATER IN EE BOILER			2008			27				31
32	LASCO ADA SHOWER			2008			27				32
33	SPRINKLERS			2010	21,859	795	27	795		4,604	33
34	NEW KITCHEN FLOORING			2010			27				34
35	AC FOR EAST DINING AREA			2010	12,294	447	27	447		2,552	35
36	SIDEWALKS			2010	14,236	420	15	420		14,236	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	1991 ADDITIONS	1991	$	$	VARIOUS	$	$	$	37
38	1992 ADDITIONS	1992			VARIOUS				38
39	1995 ADDITIONS	1995			VARIOUS				39
40	1996 ADDITIONS	1996			VARIOUS				40
41	1997 ADDITIONS	1997			VARIOUS				41
42	1998 ADDITIONS	1998	23,912		VARIOUS			23,912	42
43	1999 ADDITIONS	1999	29,814		VARIOUS			29,814	43
44	2000 ADDITIONS	2000			VARIOUS				44
45	2006 ADDITIONS	2006	11,300	667	VARIOUS	667		7,630	45
46	PATIO EAST PARKING LOT	2008			15				46
47	EAST PARKING LOT	2009	24,988	738	15	738		18,717	47
48	ASPEN Dining Room Addition - Contracted Total	2011	352,450	12,816	27	12,816		59,276	48
49	ASPEN DR Adddition, Enclosed Porch, Reconfigure some Apts	2011	3,863	141	27	141		650	49
50	Loan	2012	14,962	3,740	3	3,740		14,962	50
51	W. Building Windows	2013	38,659	1,406	27	1,406		2,853	51
52	Delta A/C Compressor	2015	3,955	63	39	63		63	52
53	E Dining Room A/C Compressor	2015	3,470	48	39	48		48	53
54	Kitchen A/C Compressor	2015	2,526	35	39	35		35	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)		$ 2,983,429	$ 59,766		$ 59,766	$	$ 2,240,595	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: 01/01/2015 Ending: 12/31/2015

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	$ 48,698	$ 670	$ 670	$		$ 46,195	71
72	Current Year Purchases	15,440	9,264	9,264			9,264	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 64,138	$ 9,934	$ 9,934	$		$ 55,459	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FORD RANGER	1992 FORD RANGER	1996	$ 3,780	$	$	$	5	$ 3,780	76
77	FORD PASSENGER	2000 13 PASSENGER VAN	2000	42,810	1,775	1,775		5	33,985	77
78	DISPOSALS								(24,845)	78
79	NON-CARE ASSETS	SEE XI-F	SEE XI-F	119,770	26,035	26,035		5	87,759	79
80	TOTALS			$ 166,360	$ 27,810	$ 27,810	$		$ 100,679	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)	$ 3,288,927	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 97,510	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 97,510	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)	$ 2,396,733	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	CHEVY VAN WITH LIFT	$ 21,065	$	$ 21,065	86
87	2013 TOYOTA CAMRY	28,664	3,050	19,310	87
88	2004 TOYOTA CAMRY	24,399		24,399	88
89	2007 CHEVROLET SILVERADO	11,000	2,200	2,200	89
90	2016 DODGE GRAND CARAVAN	34,642	20,785	20,785	90
91	TOTALS	$ 119,770	$ 26,035	$ 87,759	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: 01/01/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 33,124 Description: DISHWASHER, EQUIPMENT RENTAL
    (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.

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.

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	$	4,399	$ 292,440	$ 21	4,399	$ 292,461	1
2	Licensed Speech and Language Development Therapist		hrs		1,743	128,817	118	1,743	128,935	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,143	341,823	691	5,143	342,514	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			$	11,285	$ 763,080	$ 830	11,285	$ 763,910	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2015 (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	$ 2,077,705	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,641,614		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,574		6
7	Other Prepaid Expenses	55,605		7
8	Accounts Receivable (owners or related parties)	192,842		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,974,340	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,000		13
14	Buildings, at Historical Cost	2,968,466		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	205,653		16
17	Accumulated Depreciation (book methods)	(2,381,769)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 867,350	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,841,690	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 348,305	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	596,527		29
30	Accrued Salaries Payable	169,344		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER MISC. LIABILITIES	164,989		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,387,965	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,381		39
40	Mortgage Payable	2,849,476		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)**	$ 2,851,857	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,239,822	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 601,868	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,841,690	$	48

*(See instructions.)

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 931,188	**1**
2	Restatements (describe):		**2**
3			**3**
4			**4**
5			**5**
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 931,188	**6**
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(108,877)	**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	(220,443)	**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)**	$ (329,320)	**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)**	$ 601,868	**24** *

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

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,427,570	1
2	Discounts and Allowances for all Levels	(1,517,965)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,909,605	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,039,128	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,039,128	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	21,267	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	10,192	15
16	Rental of Facility Space		16
17	Sale of Drugs	178,311	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	179,362	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 389,132	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,259	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,259	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	OTHER REVENUE	71,335	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 71,335	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,414,459	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,813,072	31
32	Health Care	3,895,533	32
33	General Administration	1,706,551	33
	B. Capital Expense		
34	Ownership	364,232	34
	C. Ancillary Expense		
35	Special Cost Centers	411,573	35
36	Provider Participation Fee	332,375	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,523,336	40
41	**Income before Income Taxes (line 30 minus line 40)****	(108,877)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (108,877)	43

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

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

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

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

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

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,086	2,324	$ 73,828	$ 31.77	1
2	Assistant Director of Nursing	2,124	2,404	54,252	22.57	2
3	Registered Nurses	32,168	33,939	669,550	19.73	3
4	Licensed Practical Nurses	22,726	23,564	386,738	16.41	4
5	CNAs & Orderlies	105,062	108,915	1,145,811	10.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,685	1,794	21,179	11.81	9
10	Activity Assistants	17,121	17,612	155,435	8.83	10
11	Social Service Workers	7,916	8,001	112,893	14.11	11
12	Dietician					12
13	Food Service Supervisor	2,086	2,206	46,359	21.01	13
14	Head Cook	9,681	10,068	108,136	10.74	14
15	Cook Helpers/Assistants	20,897	21,535	191,966	8.91	15
16	Dishwashers					16
17	Maintenance Workers	4,733	4,906	76,076	15.51	17
18	Housekeepers	19,935	20,817	195,886	9.41	18
19	Laundry	18,406	19,000	192,512	10.13	19
20	Administrator	2,086	2,176	99,897	45.91	20
21	Assistant Administrator	394	709	30,978	43.69	21
22	Other Administrative					22
23	Office Manager	1,914	2,058	58,464	28.41	23
24	Clerical	7,889	8,170	156,244	19.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS COOR	16,815	17,969	326,376	18.16	32
33	Other(specify) Dietary Aides	7,583	7,846	69,753	8.89	33
34	TOTAL (lines 1 - 33)	303,307	316,013	$ 4,172,333 *	$ 13.20	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	243	$ 13,455	L1, C3	35
36	Medical Director		7,200	L9, C3	36
37	Medical Records Consultant		1,748	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,695	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,850	L11, C3	44
45	Social Service Consultant	24	1,850	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	291	$ 30,798		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

Facility Name & ID Number BURGIN MANOR OF OLNEY INC # 0026765 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STACY BLUE	Admin	0	$ 99,897
UNA TARPLEY	Asst. Admin	0	30,978
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 130,875

B. Administrative - Other

Description	Amount
BURGIN HEALTH MANAGEMENT	$ 226,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 226,000

C. Professional Services

Vendor/Payee	Type	Amount
BKD, LLP	Cost Report Prep	$ 6,240
BDO	Accounting/Taxes	9,106
Stone Carlie & Co.	Accounting/Taxes	19,925
Rosenblum, Golderhersh, Silverstein	Consulting	4,184
Duane Morris, LLP	Survey Review	22,871
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 62,326

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	634,438
Employee Health Insurance	163,406
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Match	51,098
Other Benefits	19,729
TOTAL (agree to Schedule V, line 22, col.8)	$ 868,671

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	$ 1,990
Advertising: Employee Recruitment	2,261
Health Care Worker Background Check (Indicate # of checks performed)	1,120
Patient Background Checks	1,100
DUES	10,919
SUBSCRIPTIONS	1,816
Less: Public Relations Expense	(754)
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,452

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 586
In-State Travel	7,560
Seminar Expense	3,396
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,542

**See instructions.

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

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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA** **$9,498.50**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **YES** If YES, what is the capacity? **161**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **6yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **50,770** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **85,958**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(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. $ **14,826**
c. What percent of all travel expense relates to transportation of nurses and patients? **42.6%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? **NO**
Indicate the amount of income earned from providing such transportation during this reporting period. $ ____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: ____

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

(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.