FOR BHF USE

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 007153

Facility Name: Burnsides Community Health Center

Address: 410-412 N. 2nd Street (Number) Marshall (City) 62441 (Zip Code)

County: Clark

Telephone Number: (217) 826-2358 **Fax #** (217) 826-2367

HFS ID Number:

Date of Initial License for Current Owners: September 1963

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501("c")(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Bernard G. Lueken **Telephone Number:** (217) 465-8562
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 07/01/2009 to 06/30/2010 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) Terry Weir
(Title) Board President

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Bernard G. Lueken, C.E.O.
(Firm Name & Address) Dimond Financial Consultants, Inc., 208 E. Jasper Street, Paris, IL 61944
(Telephone) (217) 465-8562 Fax # (217) 465-8563

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 Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 105

	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	105	Skilled (SNF)	105	38,325	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	105	TOTALS	105	38,325	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	2,220	2,133	3,569	7,922	8
9	SNF/PED					9
10	ICF	14,239	11,335	81	25,655	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,459	13,468	3,650	33,577	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.61%

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)
Meals on Wheels

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 [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started Sept. 01, 1963

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 105 and days of care provided _____

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	330,488	21,175	13,515	365,178		365,178		365,178			1
2	Food Purchase		198,431		198,431		198,431	(8,038)	190,393			2
3	Housekeeping	114,795	42,168		156,963		156,963		156,963			3
4	Laundry	130,343	21,282	4,248	155,873		155,873		155,873			4
5	Heat and Other Utilities			178,194	178,194		178,194		178,194			5
6	Maintenance	114,456	9,920	79,873	204,249		204,249		204,249			6
7	Other (specify):*											7
8	TOTAL General Services	690,082	292,976	275,830	1,258,888		1,258,888	(8,038)	1,250,850			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,033,266	288,678	97,100	2,419,044		2,419,044		2,419,044			10
10a	Therapy		538	348,525	349,063		349,063		349,063			10a
11	Activities	125,491	4,216	10,145	139,852		139,852		139,852			11
12	Social Services	63,482		2,913	66,395		66,395		66,395			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,222,239	293,432	464,683	2,980,354		2,980,354		2,980,354			16
	C. General Administration											
17	Administrative	72,026			72,026		72,026		72,026			17
18	Directors Fees											18
19	Professional Services			40,730	40,730		40,730		40,730			19
20	Dues, Fees, Subscriptions & Promotions			25,609	25,609		25,609	(17,694)	7,915			20
21	Clerical & General Office Expenses	172,935	33,588	65,271	271,794		271,794		271,794			21
22	Employee Benefits & Payroll Taxes			495,640	495,640		495,640	(5,443)	490,197			22
23	Inservice Training & Education			747	747		747		747			23
24	Travel and Seminar			1,240	1,240		1,240		1,240			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			82,167	82,167		82,167		82,167			26
27	Other (specify):*											27
28	TOTAL General Administration	244,961	33,588	711,404	989,953		989,953	(23,137)	966,816			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,157,282	619,996	1,451,917	5,229,195		5,229,195	(31,175)	5,198,020			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 Burnsides Community Health Center #007153 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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			161,970	161,970		161,970	(18,431)	143,539			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			161,970	161,970		161,970	(18,431)	143,539			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,488	57,488		57,488		57,488			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			57,488	57,488		57,488		57,488			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,157,282	619,996	1,671,375	5,448,653		5,448,653	(49,606)	5,399,047			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 Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	(8,038)	2		4
5	Telephone, TV & Radio in Resident Rooms				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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(490)	20		28
29	Other-Attach Schedule	(41,078)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,606)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (49,606)		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.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Burnsides Community Health Center

ID# 007153

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Care Depreciation	$ (18,431)	30	1
2	Employment Recognition	(5,443)	22	2
3	Patient Subscriptions	(296)	20	3
4	Other Advertising	(16,908)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(41,078)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burnsides Community Health Center **#** 007153 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,038)	0	0	0	0	0	0	0	0	0	0	(8,038)	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**	(8,038)	0	0	0	0	0	0	0	0	0	0	(8,038)	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	0	0	0	0	0	0	0	0	0	0	0	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	(17,694)	0	0	0	0	0	0	0	0	0	0	(17,694)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(5,443)	0	0	0	0	0	0	0	0	0	0	(5,443)	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**	(23,137)	0	0	0	0	0	0	0	0	0	0	(23,137)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,175)	0	0	0	0	0	0	0	0	0	0	(31,175)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burnsides Community Health Center # 007153 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(18,431)	0	0	0	0	0	0	0	0	0	0	(18,431)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	(18,431)	0	0	0	0	0	0	0	0	0	0	(18,431)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(49,606)	0	0	0	0	0	0	0	0	0	0	(49,606)	45

Facility Name & ID Number Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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
		Non-Applicable				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

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

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

Facility Name & ID Number Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	Non-Applicable								$		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 Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 6/30/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1				Non-Applicable			$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Burnsides Community Health Center **#** 007153 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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.**	$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ N/A	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.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005		**8**
	2006		**9**
	2007		**10**
	2008		**11**
	2009		**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 Burnsides Community Health Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 007153

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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,819 B. General Construction Type: Exterior Bedford St./Limestn Frame Wood Number of Stories 1

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).

Robert Flowers Village - Independent Living Facility - 8 units
Burnhaven Apartments - Independent Living Facility - 8 units
Cork Medical Center - Provides Outpatient Medical Care - Lease to Unrelated Party

All of the above facilities have their own accounting records and share no common costs with Burnsides Community Health Center.

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		226,425	1963	$ 22,963	1
2		8,400	1982	12,376	2
3	TOTALS	234,825		$ 35,339	3

Facility Name & ID Number Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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			1963	1963	$ 823,909	$ 3,323	15,30	$ 3,323	$	$ 818,289	4
5			1995	1995	1,100,822	27,521	30	27,521		410,296	5
6			1997	1997	737,255	18,431	20	18,431		235,019	6
7			1997	1997	(737,255)	(18,431)	20,30	(18,431)		(235,019)	7
8			2002	2002	3,982	199	20	199		1,532	8
	Improvement Type**										
9	Elevator			1965	8,581		20			8,581	9
10	Safety Doors and Improvements			1972	9,375		10			9,375	10
11	Improvements			1974	4,562		10			4,562	11
12	Sprinkler System			1975	39,041		20			39,041	12
13	Improvements			1977	2,892		10			2,892	13
14	Improvements			1978	636		10			636	14
15	Improvements			1979	11,842					11,842	15
16	Awning, Dining Room Windows			1981	21,654		10,30			21,654	16
17	Drapes, Guttering, Drainage Work			1982	13,093					13,093	17
18	Drapes			1983	5,526		15			5,526	18
19	Drapes, Lighting & Kitchen Cabinet Doors			1984	7,163		10,15			7,164	19
20	Fire System, Kitchen Drapes, Steel Wall Kitchen			1985	25,083		5,25			25,083	20
21	Sprinklers, Carpet, Drapes			1987	9,272		5,25			9,272	21
22	Building Improvements, Water Pump, Sewer			1988	9,350		8,20			9,350	22
23	Smoke Detector, Remodeling, Air Conditioner			1989	31,888	629	5,20	629		31,888	23
24	Door Alarm, Fire Alarms, Remodeling			1990	13,402	319	10,20	319		13,402	24
25	Remodeling			1991	5,798	120	10,20	120		5,702	25
26	Office Remodeling & Door			1993	8,177		10,20			9,774	26
27	Water System, Windows			1994	5,079		10,20			5,079	27
28	New Wing Additions			1995	88,453	5,224	10,20	5,224		77,551	28
29	Wallpaper, Blinds, Phone System			1996	4,335	217	20	217		3,076	29
30	Ceiling Work, Insulation			1997	24,991	1,249	20	1,249		15,981	30
31	Backflow System/Sprinkler System			1998	2,990	150	20	150		1,811	31
32	Roofing, Remodeling			1999	41,517	2,124	10,20	2,124		24,414	32
33	Draperies, Main Dining Room			2000	2,735	273	10	273		2,731	33
34	Windows, Dining			2000	3,620	241	15	241		2,391	34
35	Sprinkler Heads			2001	560	37	15	37		318	35
36	Lights, Call System, Remodeling, Drapes, Roof			1986	67,975		5,25			67,975	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 Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	Parking Lot	1973	$ 19,280	$	10	$	$	$ 19,280	37
38	Landscaping	1974	2,891		10			2,891	38
39	Parking Lot Improvements	1975	3,989		10			3,989	39
40	Blacktop Sealing, Culvert Installation	1980	13,853		10			13,853	40
41	Blacktop at Shed, Sewer	1981	5,170		15			5,170	41
42	Landscaping, Grading, Parking Lot Improvements	1982	15,497		5,15			15,497	42
43	Asphalt Sealing	1983	3,511		5			3,511	43
44	Landscaping, Road Improvement	1984	4,350		5,10			4,350	44
45	Landscaping at Chapel	1988	675		10			675	45
46	Landscaping	1989	220		10			220	46
47	Road Resurfacing	1990	9,188		5,15			9,188	47
48	Rock	1992	330		10			330	48
49	Asphalt Sealing	1993	20,570		5			20,570	49
50	Landscaping, Fire Hydrants	1995	4,807	294	10,20	294		4,454	50
51	Parking Lot Paving	1999	11,850		10			11,850	51
52	Landscaping	2000	500	33	19	33		356	52
53	Chapel	1985	229,191	7,284	10,30	7,284		193,382	53
54	Draperies & Carpet	1986	4,252		20			4,252	54
55	Roof - New Shingles	2002	3,819	255	15	255		2,061	55
56	Roof on Garage	2000	791	53	15	53		517	56
57	Generator, Generator Pad	2005	65,163	3,258	15	3,258		18,191	57
58	Transformer, Blinds, Wallpaper	2005	10,802	663	15	663		3,567	58
59	Paint	2005	7,018		15			7,018	59
60	Paint, Carpet	2006	4,455	297	10,20	297		1,580	60
61	Air Conditioner, Furnace, Windows, Doors	2006	12,121	985	10,20	985		3,670	61
62	Compressor, Lighting	2006	4,533	927	10,20	927		3,708	62
63	Disposal Unit, Architectual Service	2006	13,451	1,902	10,20	1,902		7,608	63
64	Water Heater, Resin Bed Tank, Plumbing, Sprinkler System	2007	33,058	2,203	10,20	2,203		5,966	64
65	Boiler, Furnace, Air Conditioner, Windows	2007	206,728	16,743	10,20	16,743		42,819	65
66	Electrical Installation, Drapes, Transmitter	2007	38,918	2,595	10,20	2,595		7,141	66
67	Conference Room Addition, Carpet, Paint	2007	107,533	7,169	10,20	7,169		17,010	67
68	Conference Room Addition	2008	129,172	7,113	10,20	7,113		11,137	68
69	IDPA Desk Review	2008	18,478					18,478	69
70	TOTAL (lines 4 thru 69)		$ 3,404,467	$ 93,400		$ 93,400	$	$ 2,124,570	70

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

Facility Name & ID Number Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	
1	Totals from Page 12A, Carried Forward		$ 3,404,467	$ 93,400		$ 93,400	$	$ 2,124,570	1
2	Asphalt	2008	1,500	100	15	100		183	2
3	Boiler	2008	43,995	2,200	20	2,200		3,300	3
4	Awning	2008	7,000	700	10	700		1,050	4
5	Compressor	2008	6,532	653	10	653		932	5
6	Sprinkler System	2008	8,539	854	20	854		1,210	6
7	Elevator	2008	4,833	483	10	483		805	7
8	Oxygen Floor Room Improvements	2009	1,362	61	15	61		61	8
9	Flooring - Office	2009	1,905	85	15	85		85	9
10	Carpet - E&F Wing	2010	1,548		7				10
11	Garbage Disposal	2010	1,558	65	10	65		65	11
12	Sump Pumps & Electrical	2010	3,271	164	15	164		164	12
13	Sprinkler System - Closets	2010	16,600	1,014	15	1,014		1,014	13
14	Sprinkler System Heads	2009	33,304	2,035	15	2,035		2,035	14
15	Sprinkler System Upgrade to Quick Response	2010	17,244	479	15	479		479	15
16	20 TON A/C Heating Unit	2010	24,915	138	15	138		138	16
17	Front Doors	2010	10,656	296	15	296		296	17
18	Flooring - Kitchen	2009	1,180	66	15	66		66	18
19	Roof	2009	40,945	1,592	15	1,592		1,592	19
20	Cabinets & Countertops	2010	1,309	7	15	7		7	20
21	Dining Room Electrical Upgrade	2010	2,959	20	15	20		20	21
22	Dining Room Replacement Windows	2010	68,294	379	15	379		379	22
23	Dining Room Replacement Doors	2010	11,250	61	15	61		61	23
24	Dining Room Roof Replacement	2010	39,246	216	15	216		216	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,754,412	$ 105,068		$ 105,068	$	$ 2,138,728	34

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

Facility Name & ID Number Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	$ 749,475	$ 34,016	$ 34,016	$	10	$ 460,387	71
72	Current Year Purchases	67,609	3,719	3,719		10	3,719	72
73	Fully Depreciated Assets	159,795				10	159,795	73
74	IDPA Desk Review	(18,478)					(18,478)	74
75	TOTALS	$ 958,401	$ 37,735	$ 37,735	$		$ 605,423	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	Local Transportation	1987 Dodge Pickup	1987	$ 8,212	$	$	$	5	$ 8,212	76
77	Local Transportation	2004 Ford Econoline	2009	1,847	369	369		5	461	77
78	Local Transportation	2004 Ford F150	2004	11,000	367	367		5	367	78
79										79
80	TOTALS			$ 21,059	$ 736	$ 736	$		$ 9,040	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)	$ 4,769,211	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,539	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,539	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)	$ 2,753,191	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	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 Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				N/A			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 ☐ NO
16. Rental Amount for movable equipment: $ Description:
(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			N/A		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 Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs			N/A			#VALUE!	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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			$		$	$		$ #VALUE!	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 Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010 (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	$ 11,334	$	1
2	Cash-Patient Deposits	11,101		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	688,220		3
4	Supply Inventory (priced at Cost)	44,865		4
5	Short-Term Investments	1,367,854		5
6	Prepaid Insurance	27,798		6
7	Other Prepaid Expenses	96,083		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,247,255	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,339		13
14	Buildings, at Historical Cost	2,672,410		14
15	Leasehold Improvements, at Historical Cost	1,858,247		15
16	Equipment, at Historical Cost	979,460		16
17	Accumulated Depreciation (book methods)	(2,991,995)		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): Oil Well Interest	176,003		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,729,464	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,976,719	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 193,233	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	286,262		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,148		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Trust Account	11,101		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 514,744	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 514,744	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,461,975	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,976,719	$	48

*(See instructions.)

Facility Name & ID Number Burnsides Community Health Center **#** 007153 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,372,219	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,372,219	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(64,648)	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) **Prior Period Adj. - Capitalize Oil Wells**	181,737	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 117,089	17
	B. Transfers (Itemize):		
18	**Interdivisional Transfer**	(27,333)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (27,333)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,461,975	24 *

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

Facility Name & ID Number Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	$ 4,305,939	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,305,939	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	608,568	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 608,568	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,038	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	251,130	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,434	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 271,602	23
	D. Non-Operating Revenue		
24	Contributions	18,490	24
25	Interest and Other Investment Income***	76,972	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 95,462	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Revenue	98	28
28a	Refunds, Rebates, & Reimbursements	102,336	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 102,434	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,384,005	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,258,888	31
32	Health Care	2,980,354	32
33	General Administration	989,953	33
	B. Capital Expense		
34	Ownership	161,970	34
	C. Ancillary Expense		
35	Special Cost Centers	57,488	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,448,653	40
41	**Income before Income Taxes (line 30 minus line 40)****	(64,648)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (64,648)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	2,054	2,080	$ 73,432	$ 35.30	1
2	Assistant Director of Nursing	2,028	2,084	40,382	19.38	2
3	Registered Nurses	8,967	9,832	215,074	21.87	3
4	Licensed Practical Nurses	34,520	38,017	732,466	19.27	4
5	CNAs & Orderlies	79,434	85,719	872,211	10.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,531	8,371	99,703	11.91	8
9	Activity Director	2,016	2,149	29,829	13.88	9
10	Activity Assistants	8,802	9,290	95,662	10.30	10
11	Social Service Workers	3,883	4,177	63,482	15.20	11
12	Dietician					12
13	Food Service Supervisor	2,079	2,080	41,212	19.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,485	29,139	289,275	9.93	15
16	Dishwashers					16
17	Maintenance Workers	6,887	7,160	114,455	15.99	17
18	Housekeepers	11,180	12,012	114,795	9.56	18
19	Laundry	10,931	12,211	130,343	10.67	19
20	Administrator	2,000	2,080	72,026	34.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,080	46,670	22.44	23
24	Clerical	7,574	8,222	126,265	15.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	218,371	236,703	$ 3,157,282 *	$ 13.34	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	192	$ 9,392	1-3	35
36	Medical Director	500 mo.	6,000	9	36
37	Medical Records Consultant	17	791	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	300 mo.	3,600	10-3	39
40	Physical Therapy Consultant	3,399	173,324	10a-3	40
41	Occupational Therapy Consultant	2,209	112,649	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,227	62,552	10a-3	43
44	Activity Consultant	51	2,832	11-3	44
45	Social Service Consultant	51	2,832	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	7,146	$ 373,972		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sean Medsker	Administrator		$ 72,026
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,026

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
DBH & Associates, LLC	Accounting	$ 9,850
Dimond Financial Consultants	Accounting	29,295
Meehling & Bernardoni	Legal	1,585
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 40,730

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 147,361
Unemployment Compensation Insurance	35,065
FICA Taxes	222,858
Employee Health Insurance	70,374
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Education, Reimb. & Recognition	14,539
TOTAL (agree to Schedule V, line 22, col.8)	$ 490,197

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)	
Dues & Subscriptions	7,915
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,915

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,240
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,240

**See instructions.

Facility Name & ID Number Burnsides Community Health Center # 007153 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Burnsides Community Health Center # 007153 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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 $5,313**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(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?

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,755** 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. $ **57,488**
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. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **None** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
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? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Sackrider & Co.**

(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.