FOR BHF USE

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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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0007153

Facility Name: Burnsides Community Health Center

Address: 410-412 N. 2nd St. (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: Sept. 1963

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Margel S. Peddicord, CPA **Telephone Number:** 217-787-8554
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 07/01/2010 to 06/30/2011 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) See Compilation Report. (Date)
(Print Name and Title) Margel S. Peddicord, CPA
(Firm Name & Address) Margel S. Peddicord, CPA, 5300 Jaeger Dr. Springfield, IL 62711
(Telephone) 217-787-8554 Fax # ( )

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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	1,343	1,921	4,002	7,266	8
9	SNF/PED					9
10	ICF	13,976	9,639	416	24,031	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,319	11,560	4,418	31,297	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.66%

D. How many bed-hold days during this year were paid by the Department? _____ (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 9/1/63

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 3,469

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/11 Fiscal Year: 6/30/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	330,458	16,775	18,140	365,373		365,373	(7,840)	357,533			1
2	Food Purchase		236,269		236,269		236,269		236,269			2
3	Housekeeping	124,485		2,309	126,794		126,794		126,794			3
4	Laundry	144,943	24,434	3,967	173,344		173,344		173,344			4
5	Heat and Other Utilities			173,287	173,287		173,287		173,287			5
6	Maintenance	38,655	11,875	58,779	109,309		109,309	4,073	113,382			6
7	Other (specify):*											7
8	TOTAL General Services	638,542	289,353	256,482	1,184,377		1,184,377	(3,767)	1,180,610			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,031,687	208,337	35,111	2,275,135		2,275,135		2,275,135			10
10a	Therapy		631	334,285	334,916		334,916		334,916			10a
11	Activities	132,622	2,061	12,697	147,380	(2,598)	144,782		144,782			11
12	Social Services	71,276	29	414	71,719	2,598	74,317		74,317			12
13	CNA Training											13
14	Program Transportation			1,060	1,060		1,060		1,060			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,235,585	211,058	389,567	2,836,210		2,836,210		2,836,210			16
	C. General Administration											
17	Administrative	70,291			70,291		70,291		70,291			17
18	Directors Fees											18
19	Professional Services			81,904	81,904		81,904		81,904			19
20	Dues, Fees, Subscriptions & Promotions			22,134	22,134		22,134	(13,851)	8,283			20
21	Clerical & General Office Expenses	158,186	13,297	39,405	210,888		210,888		210,888			21
22	Employee Benefits & Payroll Taxes			475,505	475,505		475,505		475,505			22
23	Inservice Training & Education			924	924		924		924			23
24	Travel and Seminar			260	260		260		260			24
25	Other Admin. Staff Transportation			17,277	17,277		17,277		17,277			25
26	Insurance-Prop.Liab.Malpractice			75,339	75,339		75,339		75,339			26
27	Other (specify):*			254,019	254,019		254,019	(254,019)				27
28	TOTAL General Administration	228,477	13,297	966,767	1,208,541		1,208,541	(267,870)	940,671			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,102,604	513,708	1,612,816	5,229,128		5,229,128	(271,637)	4,957,491			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 #0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			183,068	183,068		183,068	(18,250)	164,818			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			1,003	1,003		1,003	(1,003)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			184,071	184,071		184,071	(19,253)	164,818			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			151,259	151,259		151,259		151,259			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,271	64,271		64,271		64,271			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			215,530	215,530		215,530		215,530			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,102,604	513,708	2,012,417	5,628,729		5,628,729	(290,890)	5,337,839			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	(7,840)	1		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	(18,250)	30		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)	(20,188)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(866)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(232,965)	27		24
25	Fund Raising, Advertising and Promotional	(13,851)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	3,070			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (290,890)		$	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))**	$ (290,890)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Burnsides Community Health Center

ID# 0007153

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Property tax on oil well	$ (1,003)	33	1
2	Three items capitalized on books under $2,500	4,073	6	2
3	Expensed on cost report due to Medicaid rules.			3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	3,070		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burnsides Community Health Center **#** 0007153 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(7,840)	0	0	0	0	0	0	0	0	0	0	(7,840)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	4,073	0	0	0	0	0	0	0	0	0	0	4,073	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,767)	0	0	0	0	0	0	0	0	0	0	(3,767)	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	(13,851)	0	0	0	0	0	0	0	0	0	0	(13,851)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(254,019)	0	0	0	0	0	0	0	0	0	0	(254,019)	27
28	TOTAL General Administration	(267,870)	0	0	0	0	0	0	0	0	0	0	(267,870)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(271,637)	0	0	0	0	0	0	0	0	0	0	(271,637)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Burnsides Community Health Center** **# 0007153** **Report Period Beginning:** **07/01/2010** **Ending:** **06/30/2011**

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(18,250)	0	0	0	0	0	0	0	0	0	0	(18,250)	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	(1,003)	0	0	0	0	0	0	0	0	0	0	(1,003)	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**	(19,253)	0	0	0	0	0	0	0	0	0	0	(19,253)	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)**	(290,890)	0	0	0	0	0	0	0	0	0	0	(290,890)	45

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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
Not Applicable		Not Applicable		Not 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			$	Not Applicable		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Not Applicable		Not Applicable		Not Applicable			2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Not 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 # 0007153 Report Period Beginning: 07/01/2010 Ending: 6/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Not Applicable
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		Not 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										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 # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Not 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 #** _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	Not Applicable	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).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	$		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:		
2006	Not Applicable	8
2007		9
2008		10
2009		11
2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burnsides Community Health Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0007153

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		Not Applicable	$	$
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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,819 B. General Construction Type: Exterior Bedford St/Limestone 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	Nursing facility	226,425	1963	$ 22,963	1
2	Nursing facility	8,400	1982	12,376	2
3	TOTALS	234,825		$ 35,339	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	105		1963	1963	$ 823,909	$ 3,323	30	$ 3,323	$	$ 821,612	4
5			1995	1995	1,100,822	27,521	30	27,521		437,817	5
6			2002	2002	3,982	199	20	199		1,722	6
7											7
8											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					21,654	16
17	Drapes, guttering, drainage work			1982	13,093					13,093	17
18	Drapes			1983	5,526					5,526	18
19	Drapes, lighting, kitchen cabinet doors			1984	7,163					7,163	19
20	Fire System, kitchen drapes, steel wall kitchen			1985	25,083					25,083	20
21	Sprinklers, carpet, drapes			1987	9,272					9,272	21
22	Bldg improvements, water pump, sewer			1988	9,350					9,350	22
23	Smoke detector, remodeling, air conditioner			1989	31,888					31,888	23
24	Door alarm, fire alarms, remodeling			1990	13,402					13,402	24
25	Remodeling			1991	5,798	96	20	96		5,798	25
26	Office remodeling & door			1993	8,177					9,774	26
27	Water system, windows			1994	5,079					5,079	27
28	New wing additions			1995	88,453	5,224	17	5,224		82,775	28
29	Walpaper, blinds, phone system			1996	4,335	217	20	217		3,293	29
30	Ceiling work, insulation			1997	24,991	1,249	20	1,249		17,230	30
31	Blackflow system & sprinkler system			1998	2,990	150	20	150		1,961	31
32	Roofing, remodeling			1999	41,517	2,124	20	2,124		26,538	32
33	Draperies in main dining room			2000	2,735	4	10	4		2,735	33
34	Windows dining			2000	3,620	241	15	241		2,632	34
35	Sprinkler heads			2001	560	37	15	37		355	35
36	Lights, call system, remodeling, drapes, roof			1986	67,975					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 # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Parking lot	1973	$ 19,280	$		$	$	$ 19,280	37
38	Landscaping	1974	2,891					2,891	38
39	Parking lot improvements	1975	3,989					3,989	39
40	Black top sealing, culvert installation	1980	13,853					13,853	40
41	Blacktop at shed, sewer	1981	5,170					5,170	41
42	Landscaping, grading, parking lot improvements	1982	15,497					15,497	42
43	Asphalt sealing	1983	3,511					3,511	43
44	Landscaping & road improvement	1984	4,350					4,350	44
45	Landscaping	1988	675					675	45
46	Landscaping	1989	220					220	46
47	Road resurfacing	1990	9,188					9,188	47
48	Rock	1992	330					330	48
49	Asphalt sealing	1993	20,570					20,570	49
50	Landscaping, fire hydrants	1995	4,807	294	16	294		4,748	50
51	Parking lot paving	1999	11,850		10			11,850	51
52	Landscaping	2000	500	33	19	33		389	52
53	Chapel	1985	229,191	7,284	30	7,284		200,666	53
54	Draperies & carpet	1986	4,252					4,252	54
55	Roof- new shingles	2002	3,819	255	15	255		2,316	55
56	Roof on garage	2000	791	53	15	53		570	56
57	Generator & generator pad	2005	65,163	3,258	15	3,258		21,449	57
58	Transformer, blinds, wallpaper	2005	10,802	663	15	663		4,230	58
59	Paint	2005	7,018					7,018	59
60	Paint, carpet	2006	4,455	297	15	297		1,877	60
61	Air conditioner, furnace, windows, doors	2006	12,121	985	12	985		4,655	61
62	Compressor, lighting	2006	4,533	825	5	825		4,533	62
63	Disposal unit, architectual service	2006	13,451	1,902	7	1,902		9,510	63
64	Water heater, resin bed tank, plumbing, sprinkler	2007	33,058	2,203	15	2,203		8,169	64
65	Boiler, furnace, air conditioner, windors	2007	206,728	16,743	12	16,743		59,562	65
66	Electrical installation, drapes, transmitter	2007	38,918	2,595	15	2,595		9,736	66
67	Conference room addition, carpet, paint	2007	107,533	7,169	15	7,169		24,179	67
68	Conference room addition	2008	129,172	7,113	18	7,113		18,250	68
69	IDPA desk review	2008	18,478					18,478	69
70	TOTAL (lines 4 thru 69)		$ 3,404,467	$ 92,057		$ 92,057	$	$ 2,216,617	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,404,467	$ 92,057		$ 92,057	$	$ 2,216,617	1
2	Asphalt	2008	1,500	100	15	100		283	2
3	Boiler	2008	43,995	2,200	20	2,200		5,500	3
4	Awning	2008	7,000	700	10	700		1,750	4
5	Compressor	2008	6,532	653	10	653		1,585	5
6	Sprinkler system	2008	8,539	854	20	854		2,064	6
7	Elevator	2008	4,833	483	10	483		1,288	7
8	Oxygen floor room improvements	2009	1,362	91	15	91		152	8
9	Flooring office	2009	1,905	127	15	127		212	9
10	Carpet - E & F wing	2010	1,548	221	7	221		221	10
11	Garbage disposal	2010	1,558	156	10	156		221	11
12	Sump pumps & electrical	2010	3,271	218	15	218		382	12
13	Sprinkler system - closets	2010	16,600	1,107	15	1,107		2,121	13
14	Sprinkler system heads	2009	33,304	2,220	15	2,220		4,255	14
15	Sprinkler system upgrade to quick response	2010	17,244	1,150	15	1,150		1,629	15
16	20 ton AC heating unit	2010	24,915	1,661	15	1,661		1,799	16
17	Front doors	2010	10,656	710	15	710		1,006	17
18	Flooring - kitchen	2009	1,180	79	15	79		145	18
19	Roof	2009	40,945	2,730	15	2,730		4,322	19
20	Cabinets & counter tops	2010	1,309	87	15	87		94	20
21	Dining room electrical upgrade	2010	2,959	199	15	199		219	21
22	Dining room replacement windows	2010	68,294	4,552	15	4,552		4,931	22
23	Dining room replacement doors	2010	11,250	750	15	750		811	23
24	Dining room roof replacement	2010	39,246	2,616	15	2,616		2,832	24
25	Rheem furnace & radiator	2010	7,045	705	10	705		705	25
26	Door alarms & fire alarm pulls	2010	3,569	510	7	510		510	26
27	Landscaping	2010	42,099	2,475	15	2,475		2,475	27
28	Electrical: exit panels, receiver, exit lights & overhead lights	2010	4,042	279	7	279		279	28
29	Plumbing: water heater & sink,	2010	2,727	78	15	78		78	29
30	Sprinklers	2010	7,396	229	10	229		229	30
31	Paint	2010	4,849	635	5	635		635	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,826,139	$ 120,632		$ 120,632	$	$ 2,259,350	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$ 724,749	$ 39,447	$ 39,447	$		$ 533,196	71
72	Current Year Purchases	42,936	2,170	2,170		7	2,170	72
73	Fully Depreciated Assets	141,317					141,317	73
74								74
75	TOTALS	$ 909,002	$ 41,617	$ 41,617	$		$ 676,683	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	Local transportation	1987 Dodge pickup	1987	$ 8,212	$	$	$		$ 8,212	76
77	Local transportation	2004 Ford Econoline	2009	1,847	369	369		5	831	77
78	Local transportation	2004 Ford 150	2004	11,000	2,200	2,200		5	2,567	78
79										79
80	TOTALS			$ 21,059	$ 2,569	$ 2,569	$		$ 11,610	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)	$ 4,791,539	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 164,818	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 164,818	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)	$ 2,947,643	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	Not used for LTC	$ 737,255	$ 18,431	$ 253,450	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 737,255	$ 18,431	$ 253,450	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 # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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:				$ NA			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.	/2012	$
13.	/2013	$
14.	/2014	$

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			$ NA	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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		$	4,130	$	164,378	$		$ 164,378	1
2	Licensed Speech and Language Development Therapist		hrs			1,796		71,459		1,796	71,459	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs			5,053		124,866		5,053	124,866	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		7900	# of prescrpts	3,600					7,900	3,600	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				$ 3,600	10,979	$	360,703	$	14,749	$ 364,303	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Burnsides Community Health Center # 0007153 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2011 (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	$ 167,033	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	307,578		3
4	Supply Inventory (priced at)	35,083		4
5	Short-Term Investments	1,542,674		5
6	Prepaid Insurance	22,618		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,074,986	$	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	4,557,667		14
15	Leasehold Improvements, at Historical Cost	123,512		15
16	Equipment, at Historical Cost	930,061		16
17	Accumulated Depreciation (book methods)	(3,175,063)		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)**	$ 2,471,516	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,546,502	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 101,746	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,132		30
31	Accrued Taxes Payable (excluding real estate taxes)	51,591		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	Resident funds	7,092		36
37	Medicaid Liab. & other	112,702		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 458,263	$	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)**	$ 458,263	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,088,239	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,546,502	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,461,975	1
2	Restatements (describe):		2
3	Correction	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,461,979	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(373,740)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (373,740)	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)**	$ 4,088,239	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$ 4,094,734	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,094,734	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	603,854	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 603,854	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	7,794	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	296,128	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,086	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 315,008	23
	D. Non-Operating Revenue		
24	Contributions	2,390	24
25	Interest and Other Investment Income***	213,331	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 215,721	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	386	28
28a	Transp., Rent, Misc.	25,286	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 25,672	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,254,989	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,184,377	31
32	Health Care	2,836,210	32
33	General Administration	1,208,541	33
	B. Capital Expense		
34	Ownership	184,071	34
	C. Ancillary Expense		
35	Special Cost Centers	215,530	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)***	$ 5,628,729	40
41	**Income before Income Taxes (line 30 minus line 40)****	(373,740)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (373,740)	43

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

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

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

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

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	2,000	2,080	$ 71,531	$ 34.39	1
2	Assistant Director of Nursing	2,000	2,080	51,170	24.60	2
3	Registered Nurses	8,438	9,252	192,129	20.77	3
4	Licensed Practical Nurses	19,298	21,253	402,225	18.93	4
5	CNAs & Orderlies	101,719	109,729	1,165,412	10.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,095	2,233	33,225	14.88	9
10	Activity Assistants	9,936	10,492	99,397	9.47	10
11	Social Service Workers	4,330	4,656	71,276	15.31	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	40,624	19.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,403	30,146	289,835	9.61	15
16	Dishwashers					16
17	Maintenance Workers	2,367	2,461	38,655	15.71	17
18	Housekeepers	12,270	13,179	124,485	9.45	18
19	Laundry	12,840	14,346	144,943	10.10	19
20	Administrator	2,000	2,080	70,291	33.79	20
21	Assistant Administrator					21
22	Other Administrative	7,645	8,283	114,041	13.77	22
23	Office Manager	2,000	2,080	44,146	21.22	23
24	Clerical					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) Admin Nurses	6,740	7,302	149,219	20.44	33
34	TOTAL (lines 1 - 33)	225,081	243,732	$ 3,102,604 *	$ 12.73	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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	180	$ 9,820	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant	21	1,238	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	180	3,600	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	3,100	11-3	44
45	Social Service Consultant	48	3,100	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	477	$ 26,858		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	0	$ 0		53

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sean Medsker	Administrator	0	$ 70,291
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,291

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
Polsinelli Shughart	Legal	$ 7,387
Sackrider	Accounting	13,500
Dimond	Accounting	28,135
Dimond	Data Processing	11,054
Ivans, Inc.	Data Processing	1,900
MDI	Data Processing	14,130
Mediacom	Data Processing	989
Taylor Computer	Data Processing	980
Paul Robinson	Data Processing	955
Meehling & Bernardoni	Legal	98
Cardmember Services	Data Processing	867
Other	Data Processing	1,909
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 81,904

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,734
Unemployment Compensation Insurance	
FICA Taxes	314,191
Employee Health Insurance	69,272
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other benefits	926
Employee relations & activities	4,382
TOTAL (agree to Schedule V, line 22, col.8)	$ 475,505

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 510
Advertising: Employee Recruitment	230
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Advertising (See adjustment)	13,851
Dues and Subscriptions	7,543
Less: Public Relations Expense	( )
Non-allowable advertising	(13,851)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,283

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	260
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 260

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	NA		$		$	$	$	$	$ NA	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnsides Community Health Center # 0007153 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 $5,796**

(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? **N/A**

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **52,128** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **64,271**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **N/A** Has any meal income been offset against related costs? **N/A** 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? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees