FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 0007153

Facility Name: Burnsides Community Hlth Ctr

Address: 410 N 2nd St Box 219 (Number) Marshall (City) 62441 (Zip Code)

County: Clark

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

HFS ID Number:

Date of Initial License for Current Owners: 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: David Underwood **Telephone Number:** 309823-7135
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 07/01/13 to 06/30/14 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) David M. Underwood
(Title) Senior VP & CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) 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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	12,296	10,503	3,272	26,071	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,296	10,503	3,272	26,071	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.03%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 3,272

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

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

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

Tax Year: Fiscal Year:

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 **Report Period Beginning:** 07/01/13 **Ending:** 06/30/14

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	266,900	18,400		285,300		285,300		285,300			1
2	Food Purchase		175,420		175,420		175,420		175,420			2
3	Housekeeping	116,468	35,996		152,464		152,464		152,464			3
4	Laundry	84,471	12,962		97,433		97,433		97,433			4
5	Heat and Other Utilities			169,646	169,646		169,646		169,646			5
6	Maintenance	102,755	77,144	59,949	239,848		239,848		239,848			6
7	Other (specify):*											7
8	**TOTAL General Services**	570,594	319,922	229,595	1,120,111		1,120,111		1,120,111			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,545,952	108,439	5,762	1,660,153		1,660,153		1,660,153			10
10a	Therapy		113,026	550,008	663,034	(130,007)	533,027		533,027			10a
11	Activities	103,798	6,165		109,963		109,963		109,963			11
12	Social Services	37,896	394	3,979	42,269		42,269		42,269			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,687,646	228,024	565,749	2,481,419	(130,007)	2,351,412		2,351,412			16
	C. General Administration											
17	Administrative	76,228			76,228		76,228		76,228			17
18	Directors Fees											18
19	Professional Services			230,019	230,019		230,019	(6,630)	223,389			19
20	Dues, Fees, Subscriptions & Promotions			166,471	166,471	(57,488)	108,983	(9,871)	99,112			20
21	Clerical & General Office Expenses	268,139	29,754	10,584	308,477		308,477		308,477			21
22	Employee Benefits & Payroll Taxes			452,985	452,985		452,985	(38,211)	414,774			22
23	Inservice Training & Education			581	581		581		581			23
24	Travel and Seminar			11,240	11,240		11,240	(9,241)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			98,750	98,750		98,750		98,750			26
27	Other (specify):*			100,087	100,087		100,087	(100,000)	87			27
28	**TOTAL General Administration**	344,367	29,754	1,070,717	1,444,838	(57,488)	1,387,350	(163,953)	1,223,397			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,602,607	577,700	1,866,061	5,046,368	(187,495)	4,858,873	(163,953)	4,694,920			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 Hlth Ctr #0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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			188,718	188,718		188,718		188,718			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,001	5,001		5,001	(24,802)	(19,801)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,376	12,376		12,376		12,376			35
36	Other (specify):*											36
37	**TOTAL Ownership**			206,095	206,095		206,095	(24,802)	181,293			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					130,007	130,007		130,007			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					57,488	57,488		57,488			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					187,495	187,495		187,495			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,602,607	577,700	2,072,156	5,252,463		5,252,463	(188,755)	5,063,708			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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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	(24,802)			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	(38,211)			18
19	Entertainment	(9,241)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,630)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,000)			24
25	Fund Raising, Advertising and Promotional	(9,871)			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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (188,755)		$	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))**	$ (188,755)		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

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Burnsides Community Hlth Ctr

ID# **0007153**

Report Period Beginning: **07/01/13**

Ending: **06/30/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(6,630)	19	22
23				23
24		(100,000)	27	24
25		(9,871)	20	25
26				26
27		(38,211)	22	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**	(154,712)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 **Report Period Beginning:** 07/01/13 **Ending:** 06/30/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	(6,630)	0	0	0	0	0	0	0	0	0	0	(6,630)	19
20	Fees, Subscriptions & Promotions	(9,871)	0	0	0	0	0	0	0	0	0	0	(9,871)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(38,211)	0	0	0	0	0	0	0	0	0	0	(38,211)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(9,241)	0	0	0	0	0	0	0	0	0	0	(9,241)	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):*	(100,000)	0	0	0	0	0	0	0	0	0	0	(100,000)	27
28	**TOTAL General Administration**	(163,953)	0	0	0	0	0	0	0	0	0	0	(163,953)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(163,953)	0	0	0	0	0	0	0	0	0	0	(163,953)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 **Report Period Beginning:** 07/01/13 **Ending:** 06/30/14

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,802)	0	0	0	0	0	0	0	0	0	0	(24,802)	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**	(24,802)	0	0	0	0	0	0	0	0	0	0	(24,802)	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)**	(188,755)	0	0	0	0	0	0	0	0	0	0	(188,755)	45

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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
Board of Directors list attached						

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								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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Bank & Trust		x	Operations		10/12	500,000				5,001	6
7												7
8												8
9	TOTAL Facility Related						$ 500,000	$			$ 5,001	9
	B. Non-Facility Related*											
10											(24,802)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (24,802)	14
15	TOTALS (line 9+line14)						$ 500,000	$			$ (19,801)	15

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

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

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

Facility Name & ID Number Burnsides Community Hlth Ctr **#** 0007153 **Report Period Beginning:** 07/01/13 **Ending:** 06/30/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2009	8
	2010	9
	2011	10
	2012	11
	2013	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burnsides Community Hlth Ctr 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 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,819 B. General Construction Type: Exterior 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

This facility has its own accounting records and shares 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	$ 17,963	1
2	Nursing Facility	8,400	1982	12,376	2
3	TOTALS	234,825		$ 30,339	3

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	$	30	$	$	$	4
5			1995	1995	1,100,822	27,521	30	27,521			5
6			2002	2002	3,982	199	20	199			6
7											7
8											8
	Improvement Type**										
9	Elevator			1965	8,581						9
10	Safety Doors			1972	9,375						10
11	Improvements			1974	4,562						11
12	Sprinkler System			1975	39,041						12
13	Improvements			1977	2,892						13
14	Improvements			1978	636						14
15	Improvements			1979	11,842						15
16	Awning, Dining Room Windows			1981	21,654						16
17	Drapes, Guttering & Drainage			1982	13,093						17
18	Drapes			1983	5,526						18
19	Drapes, Lighting & Kitchen Cabinet Doors			1984	7,163						19
20	Fire System			1985	25,083						20
21	Sprinklers, Carpet, Drapes			1987	9,272						21
22	Bldg Improvements, Water Pump, Sewer			1988	9,350						22
23	Smoke Detector, AC			1989	31,888						23
24	Door and Fire Alarms			1990	13,402						24
25	Remodeling			1991	5,798						25
26	Office Remodel			1993	8,177						26
27	Water Systems, Windows			1994	5,079						27
28	New Wing Additions			1995	88,453	454		454			28
29	Wallpaper, Blinds & Phone System			1996	4,335	217		217			29
30	Ceiling Work, Insulation			1997	24,991	1,249		1,249			30
31	Backflow System & Sprinklers			1998	2,990	150		150			31
32	Roofing, Remodeling			1999	41,517	2,124		2,124			32
33	Drapes - Main Dining Area			2000	2,735						33
34	Windows - Dining Room			2000	3,620	241		241			34
35	Sprinkler Heads			2001	560	37		37			35
36	Lights, Call System, Remodeling			1986	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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	$		$	$	$	37
38	Landscaping	1974	2,891						38
39	Parking Lot Improvements	1975	3,989						39
40	Black Top Sealing, Culvert Install	1980	13,853						40
41	Black Top at Shed, Sewer	1981	5,170						41
42	Landscaoing & Grading	1982	15,497						42
43	Asphalt Sealing	1983	3,511						43
44	Landscaping	1984	4,350						44
45	Landscaping	1988	675						45
46	Landscaping	1989	220						46
47	Road Resurfacing	1990	9,188						47
48	Rock	1992	330						48
49	Asphalt Sealing	1993	20,570						49
50	Landscaping, Fire Hydrants	1995	4,807						50
51	Parking Lot Paving	1999	11,850						51
52	Landscaping	2000	500	33		33			52
53	Chapel	1985	229,191	7,284		7,284			53
54	Draperies & Carpet	1986	4,252						54
55	Roof - New Shingles	2002	3,819	255		255			55
56	Garage Roof	2000	791	53		53			56
57	Generator and Pad	2005	65,163	3,258		3,258			57
58	Transformer, Blinds & Wallpaper	2005	10,802	663		663			58
59	Painting	2005	7,018						59
60	Painting and Carpet	2006	4,455	297		297			60
61	AC, Furnace, Windows, Doors	2006	12,121	985		985			61
62	Compressor, Lightling	2006	4,533						62
63	Disposal Unit, Architect Services	2006	13,451	1,902		1,902			63
64	Water Heater, Plumbing, Sprinkler	2007	33,058	2,203		2,203			64
65	Boiler, Furnace, AC, Windows	2007	206,728	16,743		16,743			65
66	Electrical Installation, Drapes & Transmitter	2007	38,918	2,595		2,595			66
67	Conference Room Addition	2007	107,533	7,169		7,169			67
68	Conference Room Addition	2008	129,172	7,113		7,113			68
69	IDPA Desk Review	2008	18,478						69
70	TOTAL (lines 4 thru 69)		$ 3,404,467	$ 82,745		$ 82,745	$	$	70

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	$ 82,745		$ 82,745	$	$	1
2	Asphalt	2008	1,500	100		100			2
3	Boiler	2008	43,995	2,200		2,200			3
4	Awning	2008	7,000	700		700			4
5	Compressor	2008	6,532	653		653			5
6	Sprinkler System	2008	8,539	854		854			6
7	Elevator	2008	4,833	483		483			7
8	Oxygen Room Improvements	2009	1,362	91		91			8
9	Office Flooring	2009	1,905	127		127			9
10	Carpet - E&F Wings	2010	1,548	221		221			10
11	Garbage Disposal	2010	1,558	156		156			11
12	Sump Pump & Electrical	2010	3,271	218		218			12
13	Sprinkler System-Closets	2010	16,600	1,107		1,107			13
14	Sprinkler System - Heads	2009	33,304	2,220		2,220			14
15	Sprinkler System - Upgrade to Quick Response	2010	17,244	1,150		1,150			15
16	20 Ton AC/Heating Unit	2010	24,915	1,661		1,661			16
17	Front Doors	2010	10,656	710		710			17
18	Flooring-Kitchen	2009	1,180	79		79			18
19	Roof	2009	40,945	2,730		2,730			19
20	Cabinets & Countertops	2010	1,309	87		87			20
21	Dining Room - Electrical Upgrades	2010	2,959	199		199			21
22	Dining Room Replacement Windows	2010	68,294	4,552		4,552			22
23	Dining Room Replacement Doors	2010	11,250	750		750			23
24	Dining Room - Roof Replacement	2010	39,246	2,616		2,616			24
25	Furnace & Radiator	2010	7,045	705		705			25
26	Door and Fire Alarm Pulls	2010	3,569	510		510			26
27	Landscaping	2010	42,099	2,807		2,807			27
28	Exit Panels and Lights	2010	4,042	577		577			28
29	Water Heater and Sink	2010	2,727	182		182			29
30	Sprinklers and Sink	2010	7,396	740		740			30
31	Paint	2010	4,849	969		969			31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,826,139	$ 112,899		$ 112,899	$	$	34

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,826,139	$ 112,899		$ 112,899	$	$	1
2	Concrete driveway and parking lot	2011	17,084	1,138		1,138			2
3	Install sprinklers	2011	4,056	270		270			3
4	Install exhaust fan and hood	2011	10,400	693		693			4
5	Install emergency lights	2011	4,017	268		268			5
6	Replace gas water heater	2012	22,910	1,527		1,527			6
7	Install furnace	2012	3,813	169		169			7
8	Install new air conditioner	2012	7,308	325		325			8
9	Replace air conditioner condenser	2013	2,257	13		13			9
10	Install new carpet - F Wing	2013	849	61		61			10
11	Replace heat exchanger	2013	1,424	16		16			11
12	Purchase new computer server	2012	15,594	2,339		2,339			12
13	Purchase new floor scrubber	2013	791	9		9			13
14	Replace garbage disposal	2013	1,799	45		45			14
15	Install Wanderguard system	2013	4,863	365		365			15
16									16
17	Walk In Freezer	2014	3,607	200		200			17
18	Lighting Retrofit - 14 rooms	2014	12,174						18
19	Acquisition and connection of 3 Milnor commercial dryers	2014	27,529	367		367			19
20	Cabling for internet and new wireless system	2014	23,500	1,175		1,175			20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,990,114	$ 121,879		$ 121,879	$	$	34

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	$ 807,927	$ 64,270	$ 64,270	$		$	71
72	Current Year Purchases	62,902						72
73	Fully Depreciated Assets	141,317						73
74								74
75	TOTALS	$ 1,012,146	$ 64,270	$ 64,270	$		$	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 Transport	2004 Ford Econoline	2009	$ 1,847	$ 369	$ 369	$		$	76
77	Local Transport	2004 Ford F150	2011	11,000	2,200	2,200				77
78										78
79										79
80	TOTALS			$ 12,847	$ 2,569	$ 2,569	$		$	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)	$ 5,045,446	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 188,718	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 188,718	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)	$	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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable
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							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.	/2015	$
13.	/2016	$
14.	/2017	$

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					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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	$		$ 215,814	$		$ 215,814	1
2	Licensed Speech and Language Development Therapist		hrs			27,820			27,820	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			288,261	1,132		289,393	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				111,894		111,894	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					18,113			18,113	13
14	TOTAL			$		$ 550,008	$ 113,026		$ 663,034	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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/14 (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	$ 112,163	$	1
2	Cash-Patient Deposits	9,693		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	661,980		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,228		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)**	$ 842,064	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	170,935		13
14	Buildings, at Historical Cost	4,691,625		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,028,205		16
17	Accumulated Depreciation (book methods)	(3,741,972)		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)**	$ 2,148,793	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,990,857	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 311,534	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,693		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	197,873		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,044		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	Bed Tax	69,514		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 600,658	$	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)**	$ 600,658	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,390,199	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,990,857	$	48

***(See instructions.)**

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,565,472	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,565,472	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(883,585)	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)**	$ (883,585)	17
	B. Transfers (Itemize):		
18	**Transfer to Related Party**	(291,688)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (291,688)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,390,199	24 *

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,058,727	1
2	Discounts and Allowances for all Levels	(1,343,441)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,715,286	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,436,854	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,436,854	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	188,702	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,234	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 191,936	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,802	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,802	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,368,878	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,120,111	31
32	Health Care	2,481,419	32
33	General Administration	1,444,838	33
	B. Capital Expense		
34	Ownership	206,095	34
	C. Ancillary Expense		
35	Special Cost Centers		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)***	$ 5,252,463	40
41	**Income before Income Taxes (line 30 minus line 40)****	(883,585)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (883,585)	43

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

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	1,914	2,080	$ 61,389	$ 29.51	1
2	Assistant Director of Nursing	434	472	9,753	20.66	2
3	Registered Nurses	8,366	9,093	239,049	26.29	3
4	Licensed Practical Nurses	19,691	21,403	449,655	21.01	4
5	CNAs & Orderlies	60,211	65,447	718,230	10.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,447	3,747	67,876	18.11	8
9	Activity Director					9
10	Activity Assistants	7,890	8,576	103,798	12.10	10
11	Social Service Workers	2,045	2,223	37,896	17.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,951	23,860	266,900	11.19	15
16	Dishwashers					16
17	Maintenance Workers	5,558	6,041	102,755	17.01	17
18	Housekeepers	10,655	11,581	116,468	10.06	18
19	Laundry	8,005	8,701	84,471	9.71	19
20	Administrator	1,913	2,080	76,228	36.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,274	13,341	268,139	20.10	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)	164,354	178,645	$ 2,602,607 *	$ 14.57	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		$ 0		35
36	Medical Director		6,000		36
37	Medical Records Consultant		613		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,301		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,979		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,893		49

C. CONTRACT NURSES

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Deb Gill		0	$ 76,228
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,228

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
Heritage Operations Group	Mgt	$ 165,596
Diamond Financial	Accounting	22,104
Sackrider & Co	Audit	31,773
ADP	Payroll	500
Legal adj to Zero		10,046
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 230,019

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,554
Unemployment Compensation Insurance	21,722
FICA Taxes	199,099
Employee Health Insurance	98,909
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	13,490
TOTAL (agree to Schedule V, line 22, col.8)	$ 414,774

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	10,830
Health Care Worker Background Check	
(Indicate # of checks performed)	2,320
Patient Background Checks	
PR	6,637
Dues & Subscriptions	365
License & Fees	85,597
Less: Public Relations Expense	(6,637)
Non-allowable advertising	(0)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 99,112

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	10,209
	384
Seminar Expense	647
	(9,241)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/13 Ending: 06/30/14

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? **No**
If YES, give association name and amount.

(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? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** 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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,135**

(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. $
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? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

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

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg 5 Line #	Adjustment Amount
1009	PETTY CASH	112,163					
1010	CASH IN BANK						
1040	CASH IN BANK-PAYROLL						
1100	ACCOUNTS RECEIVABLE	661,980					
1110	MEDICARE RECEIVABLES						
1125	IPA INCOME RECEIVABLE						
1130	MEDICARE COST REPORT						
1135	ACCOUNTS RECEIVABLE-IC						
1140	UNAPPLIED CASH RECEIPTS						
1145	A/R SUSPENSE-REFUNDS						
1190	ACCRUED INTEREST REC						
1200	PREPAID INSURANCE	58,228					
1220	OTHER PREPAID EXPENSES						
1300	FOOD INVENTORY						
1310	SUPPLIES INVENTORY						
1409	LAND	170,935					
1450	FURNITURE & EQUIPMENT	1,028,205					
1460	ACCUM DEPR-FURN & EQUIP	-835,971					
1475	BUILDING & IMPROVEMENTS	4,691,625					
1490	ACCUM DEPR-BUILDING	-2,906,001					
1530	RESIDENT FUNDS	9,693					
1550	LOAN FEES	0					
1560	REAL ESTATE TAX ESCROW						
1575	REIMBURSABLE PURCHASES						
1850	INTRACOMPANY	0					
2010	ACCOUNTS PAYABLE	-311,534					
2095	BONUSES PAYABLE						
2100	ACCRUED PAYROLL	-64,145					
2110	ACCRUED VACATION PAY	-133,728					
1,009	1,009	PETTY C/	112,163				
1,100	1,100	ACCTS R	661,980				
1,101	1,101	ALLOW. FOR UNCOLLECTIBLE					
1,110	1,110	ACCTS RECEIV-M/C					
1,125	1,125	ACCTS RECEIV-IPA					
1,135	1,135	ACCTS RECEIV-IC					
1,140	1,140	UNAPPLIED CASH RECEIPTS					
1,145	1,145	A/R SUSPENSE-REFUNDS					
1,200	1,200	PREPAID	58,228				
1,220	1,220	OTHER PREPAID EXPENSES					
1,300	1,300	DIETARY INVENTORY					
1,310	1,310	SUPPLIES INVENTORY					
1,320	1,320	LINEN INVENTORY					
1,409	1,409	LAND	170,935				
1,450	1,450	FURNITU	1,028,205				
1,460			(835,971)				
1,475	1,475	CODE AL	4,691,625				
1,490	1,490	ACCUM I	(2,906,001)				
1,530	1,530	RESIDEN	9,693				
1,550	1,550	LOAN FE	0				
1,551	1,551	LOAN FEES ADDED					
1,850	1,850	INTERCO	0				
2,010	2,010	ACCOUN	(311,534)				
2,100	2,095	BONUSES PAYABLE					
2,100	2,100	ACCRUEI	(64,145)				
2,100	2,100	PR CLEARING-BENEFITS					
2,100	2,100	PR CLEARING-LABOR					
2,110	2,110	ACCRUEI	(133,728)				
2,120	2,120	U.C. TAX	0				

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	-12,044	-12,044
2130	FIT PAYABLE		
2140	STATE W/H PAYABLE		0
2145	EARNED INCOME CREDIT		
2150	UC FED CREDIT REDUCTION		
2230	PAYROLL SAVINGS		
2235	IRA W/HOLDINGS		
2240	UNITED WAY		
2245	GROUP INSURANCE PAYABLE		
2246	GROUP INSURANCE PAYABLE-CAFETERIA		
2260	WAGE GARNISHMENTS		
2280	MISC PAYROLL DEDUCTIONS		
2300	ACCRUED INTEREST PAYABLE	0	
2310	SALES TAX PAYABLE		
2320	IPA PAYMENTS PAYABLE	-69,514	
2350	REAL ESTATE TAX PAYABLE	0	
2385	ACTIVITY FUND	0	
2390	SECURITY DEPOSITS	0	
2391	VOLUNTEER FUND		
2393	HEART FUND/BAZAAR		
2395	DEFERRED INC EMP & MEM		
2400	CURRENT PORTION LT DEBT		
2460	INCOME TAXES PAYABLE		
2512	DUE TO RESIDENTS	-9,693	
2600	MORTGAGE PAYABLE	0	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	-3,273,785	
2970	PROFIT/LOSS FOR PERIOD	883,586	
3007.1	PATIENT DAYS-PRIVATE	10,503	

2,125	2,125	FICA TAX	(12,044)
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REFU	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETER	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GA	
2,300	2,300	ACCRUEI	0
2,320	2,320	IPA PAYM	(69,514)
2,350	2,350	REAL EST	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEB	
2,512	2,512	DUE TO F	(9,693)
2,600	2,600	LASALLE	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEB	
2,720	2,720	RETAINE	(3,273,785)
		net income	883,586
		balance	0

3,007

3007.2		PATIENT DAYS-IPA	12,296					3,007
3007.3		PATIENT DAYS-MEDICARE	3,272					3,007
3007.4		PATIENT DAYS-CONVERSION						3,007
3007.5		PATIENT DAYS-LICENSED						3,007
3007.6		PATIENT DAYS-TOTAL						3,007
3010	1	BASIC CHARGE-PRIVATE & VA	-4,043,100	0	0	0	0	3,007
3015	1	PRIVATE ASSESSMENT TAX INCOME		0	0	0	0	3,010
3020	1	BASIC CHARGE-IPA	0	0	0	0	0	3,020
3030	1	BASIC CHARGE-MEDICARE	0	0	0	0	0	3,030
3035	4	DAY CARE/HOME CARE		0	0	0	0	3,040
3040	1	LIGHT NURSING CARE	0	0	0	0	0	3,050
3050	1	MEDIUM NURSING CARE		0	0	0	0	3,060
3060	1	HEAVY NURSING CARE		0	0	0	0	3,061
3061	1	SKILLED NURSING CARE						3,080
3080	1	NURSING SUPPLIES-PRIVATE	-11,116	0	0	0	0	3,081
3081	1	NURSING SUPPLIES-IPA		0	0	0	0	3,082
3082	1	NURSING SUPPLIES MED PT A		0	0	0	0	3,083
3083	1	NURSING SUPPLIES MED PT B						3,100
3100	17	DRUGS	-188,702	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-1,436,854	0	0	0	0	3,111
3111	6	PT-IPA		0	0	0	0	3,112
3112	6	PT-MEDICARE PART A		0	0	0	0	3,113
3113	6	PT-MEDICARE PART B		0	0	0	0	3,140
3130	1	PUBLIC AID ASSESSMENT INC						3,150
3140	19	LABORATORY INCOME		0	0	0	0	3,151
3150	6	SPEECH/OT-PRIVATE		0	0	0	0	3,152
3151	6	SPEECH/OT-IPA		0	0	0	0	3,153
3152	6	SPEECH/OT-MED PART A		0	0	0	0	3,160
3153	6	SPEECH/OT MED PART B						3,410
3410	2	IPA DISCOUNTS	1,343,441	0	0	0	0	3,411
3411	2	MEDICAID PART B DISCOUNT		0	0	0	0	3,420
3420	2	MEDICARE DISCOUNTS		0	0	0	0	3,500

3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0			3,520
3520		16	RENT INCOME	0		6	0	6	0			3,530
3530		13	BEAUTY SHOP	0		0	0	0	0			3,560
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0			3,570
3570		12	VENDING INCOME/EXPENSE	-28		0	0	0	0			3,590
3580		12	MANAGEMENT FEES			0	0	0	0			3,595
3590		1	EQUIPMENT RENTAL	-4,511		0	0	0	0			3,600
3595		21	RESIDENT TRANSPORTATION	-2,670		0	0	0	0			4,110
3600		21	MISC INCOME	-536		0	0	0	0			4,111
4110			GENERAL & ADMINIST WAGES	252,190	268,139	21	1	17	0			4,115
4111			ADMINISTRATOR WAGES	76,228	76,228	17	1	0	0			4,120
4115			VACATION & SICK - G&A	15,949		21	1	0	0			4,121
4120	4475		EMPLOYEE BENEFITS	13,490	452,985	22	3	0	0			4,130
4125			EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0			4,135
4130			EMPLOYEE SCHOLORSHIP WAGE	0		21	1	0	0			4,250
4135			EMPLOYEE SCHOLORSHIP COST	0		23	3	0	0			4,255
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260
4250	4255		OFFICE SUPPLIES	29,754	29,754	21	2	0	0			4,275
4260			TELEPHONE	10,584	10,584	21	3	0	0			4,276
4275			TRAINING & EMPLOYEE DEVL	581	581	23	3	16	0	**		4,280
4280			GENERAL TRAVEL	10,209	11,240	24	3	16	0			4,281
4281			MEAL EXPENSE FOR TRAVEL	384		24	3	19	0			4,285
4285			EDUCATION & SEMINAR	647		24	3	19	-9,241	***		4,289
4290			HELP WANTED ADVERTISING	10,830	166,471	20	3	0	0		-57,488	4,290
4291			PROMOTIONAL ADVERTISING	3,234		20	3	25	-3,234			4,291
4292			PUBLIC RELATIONS	6,637		20	3	25	-6,637			4,292
4300			LICENSES & FEES	143,085		20	3	17	0			4,300
4310			DUES & SUBSCRIPTIONS	365		20	3	17	0			4,310
4320			CONTRIBUTIONS	0		27	3	20	0			4,320
4350			PROFESSIONAL FEES	64,423	230,019	19	3	22	-10,046			4,350
4355			MEDICAL DIRECTOR	6,000	6,000	9	3	0	0			4,355
4360			UTILIZATION REVIEW	0		10	3	0	0			4,362
4361			OTHER PHYSICIAN FEES			39	3	0	0			4,363

4362	MEDICAL RECORDS CONSULT	613		10	3	0	0		4,364
4363	PHARMACIST FEES	4,301		10	3	0	0		4,370
4364	SOC SERV/ACT CONSULT	3,979	3,979	12	3	0	0		4,383
4370	TV RENTAL	0		35	3	5	0		4,390
4380	INCOME TAXES		100,087	27	3	26	0		4,400
4383	BACKGROUND CHECKS	2,320		20	3	26	0		4,401
4400	PAYROLL TAXES	214,735		22	3	0	0		4,410
4401	PAYROLL TAXES ADMINIST	6,086		22	3	0	0		4,420
4410	GROUP INSURANCE	98,909		22	3	0	0		4,430
4420	LIABILITY INSURANCE	98,750	98,750	26	3	0	0		4,435
4425	INSURANCE-OWNERS			22	3	21	0		4,436
4430	WORKMENS COMP INSURANCE	81,554		22	3	0	0		4,450
4450	CENTRAL OFFICE FEES	165,596		19	3	34	0	**	4,460
4460	BAD DEBTS	100,000		27	3	24	-100,000		4,461
4470	LOST ITEMS-RESIDENTS	87		27	3	0			4,470
4490	MISCELLANEOUS	0		27	3	0	0		4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0		4,486
4600	LEASED EQUIPMENT	12,376	12,376	35	3	16	0		4,490
5110	MAINTENANCE SALARIES	95,243	102,755	6	1	0	0		4,496
5120	MAINTENANCE SICK & VAC	7,512		6	1	0	0		4,510
5130	ELECTRIC	100,518	169,646	5	3	0	0		4,600
5131	NATURAL GAS	40,119		5	3	0	0		5,110
5132	HEATING & DEISEL OIL			5	3	0	0		5,120
5133	WATER & SEWER	29,009		5	3	0	0		5,130
5134	TRASH COLLECTION	11,314	59,949	6	3	0	0		5,131
5140	PROPERTY PLANT REPLACEMNT	22,613	77,144	6	2	0	0		5,133
5160	GENERAL REPAIR & MAINT	54,531		6	2	0	0		5,134
5165	MAINTENANCE CONTRACTS	48,635		6	3	0	0		5,140
5210	DIETARY WAGES	250,897	266,900	1	1	0	0		5,160
5220	DIETARY SICK & VAC	16,003		1	1	0	0		5,165
5240	SALES TAX			2	3	13	0		5,210
5248	FOOD PURCHASES	181,555	175,420	2	2	0	0		5,220
5250	SUPPLIES-DISHWASHING	6,863	18,400	1	2	0	0		5,248

5260	DIETARY REPLACEMENT	2,864		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	8,673		1	2	0	0	5,260
5295	MEAL CREDIT	-6,135		2	2	0	0	5,270
5310	LAUNDRY WAGES	82,399	84,471	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,072		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	5,335	12,962	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	7,627		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	111,168	116,468	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	5,300		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	24,806	35,996	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	11,190		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,545,952	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	225,808		10	1	0	0	6,020
6030	DON WAGES	61,389		10	1	0	0	6,030
6035	ADON	9,753		10	1	0	0	6,035
6040	RN SICK & VACATION	13,241		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	430,862		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICARE	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	18,793		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	692,913		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	25,317		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING REIMB	0		0	0	0	0	6,295
6270	REHAB WAGES	58,174		10	1	0	0	6,390
6275	REHAB SICK & VAC	9,702		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	16,036	108,439	10	2	0	0	7,281
6295	NURSING SUPPLIES	84,753		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	7,650		10	2	0	0	7,391
6490	NURSING OTHER	848	5,762	10	3	0	0	7,393
7280	DRUG PURCHASES	76,777	113,026	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	35,117		39	2			7,540
7380	LABORATORY SERVICES	18,113	550,008	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	97,986	103,798	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	5,812		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	6,165	6,165	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	288,261		39	3	0	0 ***	7,890
7660	PT SUPPLIES	1,132		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	35,511	37,896	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	2,385		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	394	394	12	2	0	0	8,130
7740	OT FEE	215,814		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	27,820		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	0	0	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	5,001	5,001	32	3	14	-24,802	
8130	DEPRECIATION	188,718	188,718	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-24,802		32	0	10	0	
9520	MISC NON-OPERATING INCOME	0		0	0	0	0	
9700	INCOME TAXES	38,211		0	0	0	-38,211	
		5,227,661	5,252,463					
			24,802					
GRAND TOTALS		883,585					-192,171	
		(NET INCOME)						
		0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	10,503	10,503
IPA	12,296	12,296
medic	3,272	3,272
		26,071

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3,007 PATIENT 10,503

3,007	PATIENT	12,296
3,007	PATIENT	3,272
		0
3,010	BASIC CI	(4,043,100)
3,020	BASIC CI	0
3,030	BASIC CI	0
		0
		0
		0
		0
3,080	NURSING	(11,116)
3,081	NURSING	0
3,082	NURSING	0
3,083	NURSING	0
3,100	DRUGS-N	(188,702)
		0
3,110	PHYSICA	(1,436,854)
		0
3,112	PHYSICA	0
3,113	PHYSICA	0
3,140	LABORATORY INCOME	
		0
3,152	ST/OT TH	0
3,153	ST/OT TH	0
3,185	REHAB/ISOLATION/OTHER CHG	
3,410	IPA/OTH	0
3,411	MEDICA	0
3,420	MEDICA	1,302,882

3,520	RENT IN(	0
3,530	BEAUTY	0
		0
3,570	VENDIN(	(28)
3,590	EQUIPMI	(4,511)
3,595	RESIDEN	(2,670)
3,600	MISC IN(	(536)
4,110	G&A WA	252,190
4,111	ADMINIS	76,228
4,115	G&A PT(	15,949
4,120	EMPLOY	10,073
4,130	EMPLOY	0
4,135	EMPLOY	0
4,250	OFFICE S	17,891
4,255	POSTAG	3,208
4,260	TELEPH(	10,584
4,275	TRAININ	581
		0
4,280	GENERA	10,209
4,281	MEAL E)	384
4,285	EDUCAT	647
4,289	MEETIN(	0
4,290	HELP W/	10,830
4,291	PROMOT	3,234
4,292	PUBLIC I	6,637
4,300	LICENSE	143,085
4,310	DUES & S	365
4,320	CONTRI	0
4,350	PROFESS	64,423
4,355	MEDICA	6,000
		613
		4,301

4,364	SOCIAL S	3,979
4,370	TV RENT	0
4,383	BACKGR	2,320
4,390	OTHER T	38,285
4,400	PAYROL	214,735
4,401	PAYROL	6,086
4,410	GROUP I	98,909
4,420	LIABILIT	98,750
4,430	WORKM	78,814
4,435	W/C-FIRS	812
4,436	DRUG TE	1,928
4,450	MANAGI	165,596
4,460	BAD DEI	100,000
4,461	BAD DEI	40,559
4,470	LOST ITI	87
4,475	UNIFORM	3,417
4,486	SERVICE	16,796
4,490	MISC EX	1,635
4,496	MISC. M.	8,655
4,510	REAL ES	0
4,600	LEASED	12,376
5,110	MAINTEI	95,243
5,120	MAINTEI	7,512
5,130	ELECTRI	100,518
5,131	NATURA	40,119
5,133	WATER &	29,009
5,134	TRASH C	11,314
5,140	PROP/PL	22,613
5,160	GENERA	54,531
5,165	MAINTEI	31,839
5,210	DIETARY	250,897
5,220	DIETARY	16,003
5,248	FOOD PU	179,920

5,250	SUPPLIE	6,863
5,260	REPLACI	2,864
5,270	KITCHEN	8,673
5,295	MEAL IN	(6,135)
5,310	LAUNDR	82,399
5,340	LAUNDR	2,072
5,370	REPLACI	5,335
		0
5,390	SUPPLIE	7,627
5,410	HOUSEK	111,168
5,440	HOUSEK	5,300
5,480	SUPPLIE	24,806
5,490	SUPPLIE	11,190
6,020	RN WAG	225,808
6,030	DON WA	61,389
6,035	ADON W	9,753
6,040	RN PTO &	13,241
6,120	LPN WAG	430,862
6,140	LPN PTO	18,793
6,220	AIDES W	692,913
6,240	AIDES PT	25,317
		0
		0
		0
6,270	REHAB V	58,174
6,275	REHAB P	9,702
6,290	NURSING	16,036
6,295	NURSING	84,753
6,390	REPLACI	7,650
6,490	OTHER	848

7,280	DRUG PU	76,777
7,281	DRUG PU	35,117
7,380	LABORA	7,416
7,390	X-RAY S	10,697
		0
7,510	ACTIVIT	97,986
7,540	ACTIVIT	5,812
7,590	ACTIVIT	6,165
7,620	PHYSICA	288,261
7,660	P.T. SUPI	1,132
7,710	SOCIAL S	35,511
7,720	SOCIAL S	2,385
7,730	SOCIAL S	394
7,740	OCCUPA	215,814
7,770	SPEECH	27,820
7,820	BEAUTIC	0
		0
		0
8,120	INTERES	5,001
		0
8,130	DEPRECI	188,718
		0
9,510	INTERES	(24,802)
9,520	MISC NO	(74)
4,220		0
8,100		0
9,702		0
5,230		0
		883,585

Expenses Fixed Assets

0