FOR BHF USE

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

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 Bx 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:

	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		

(VOLUNTARY,NON-PROFIT: x)

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 07/01/14 to 06/30/15 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) EVP & 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: 07/01/14 Ending: 06/30/15

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,674	12,448	2,209	25,331	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,674	12,448	2,209	25,331	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.10%

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 2,209

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: 07/01/14 Ending: 06/30/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	216,000	12,084		228,084		228,084		228,084			1
2	Food Purchase		164,909		164,909		164,909		164,909			2
3	Housekeeping	124,406	36,053		160,459		160,459		160,459			3
4	Laundry	62,105	8,890		70,995		70,995		70,995			4
5	Heat and Other Utilities			144,973	144,973		144,973		144,973			5
6	Maintenance	99,692	56,063	52,745	208,500		208,500		208,500			6
7	Other (specify):*											7
8	TOTAL General Services	502,203	277,999	197,718	977,920		977,920		977,920			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,464,828	111,687	6,275	1,582,790		1,582,790		1,582,790			10
10a	Therapy		78,444	400,948	479,392	(86,386)	393,006		393,006			10a
11	Activities	79,354	6,556		85,910		85,910		85,910			11
12	Social Services	34,175		5,175	39,350		39,350		39,350			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,578,357	196,687	418,398	2,193,442	(86,386)	2,107,056		2,107,056			16
	C. General Administration											
17	Administrative	77,171			77,171		77,171		77,171			17
18	Directors Fees											18
19	Professional Services			235,234	235,234		235,234	(3,860)	231,374			19
20	Dues, Fees, Subscriptions & Promotions			74,909	74,909	(57,488)	17,421	(15,163)	2,258			20
21	Clerical & General Office Expenses	222,855	24,049	9,943	256,847		256,847		256,847			21
22	Employee Benefits & Payroll Taxes			419,512	419,512		419,512		419,512			22
23	Inservice Training & Education			2,636	2,636		2,636		2,636			23
24	Travel and Seminar			8,800	8,800		8,800	(3,801)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			97,314	97,314		97,314		97,314			26
27	Other (specify):*			24,058	24,058		24,058	(24,000)	58			27
28	TOTAL General Administration	300,026	24,049	872,406	1,196,481	(57,488)	1,138,993	(46,824)	1,092,169			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,380,586	498,735	1,488,522	4,367,843	(143,874)	4,223,969	(46,824)	4,177,145			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.

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			198,554	198,554		198,554		198,554			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			148	148		148	(1,315)	(1,167)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,885	13,885		13,885		13,885			35
36	Other (specify):*											36
37	**TOTAL Ownership**			212,587	212,587		212,587	(1,315)	211,272			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					86,386	86,386		86,386			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**					143,874	143,874		143,874			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,380,586	498,735	1,701,109	4,580,430		4,580,430	(48,139)	4,532,291			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: 07/01/14 Ending: 06/30/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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	(1,315)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,801)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,860)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)			24
25	Fund Raising, Advertising and Promotional	(15,163)			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)**	$ (48,139)		$	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))**	$ (48,139)		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

STATE OF ILLINOIS

Burnsides Community Hlth Ctr

ID# 0007153

Report Period Beginning: 07/01/14

Ending: 06/30/15

	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		(3,860)	19	22
23				23
24		(24,000)	27	24
25		(15,163)	20	25
26				26
27		0	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**	(43,023)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/14 Ending: 06/30/15

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

	Operating Expenses A. General Services	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)	
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	(3,860)	0	0	0	0	0	0	0	0	0	0	(3,860)	19
20	Fees, Subscriptions & Promotions	(15,163)	0	0	0	0	0	0	0	0	0	0	(15,163)	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	(3,801)	0	0	0	0	0	0	0	0	0	0	(3,801)	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):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	27
28	**TOTAL General Administration**	(46,824)	0	0	0	0	0	0	0	0	0	0	(46,824)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,824)	0	0	0	0	0	0	0	0	0	0	(46,824)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/14 Ending: 06/30/15

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	(1,315)	0	0	0	0	0	0	0	0	0	0	(1,315)	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**	(1,315)	0	0	0	0	0	0	0	0	0	0	(1,315)	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)**	(48,139)	0	0	0	0	0	0	0	0	0	0	(48,139)	45

Facility Name & ID Number: Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/14 Ending: 06/30/15

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: 07/01/14 Ending: 06/30/15

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: 07/01/14 Ending: 06/30/15

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
					Compensation Received From Other 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	
	Name	Title	Function	Ownership Interest		Hours	Percent	Description	Amount		
1	List of Board Members Attached								$		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: 07/01/14 Ending: 06/30/15

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Bank & Trust										148	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 148	9
	B. Non-Facility Related*											
10	Interest Income										(1,315)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,315)	14
15	TOTALS (line 9+line14)						$	$			$ (1,167)	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:** 07/01/14 **Ending:** 06/30/15

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2014 report.	$		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 2015 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:			
	2010		**8**
	2011		**9**
	2012		**10**
	2013		**11**
	2014		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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	2	3	4	
	Use	Square Feet	Year Acquired	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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/14 Ending: 06/30/15

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		30				5
6			2002	2002	3,982		20				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						28
29	Wallpaper, Blinds & Phone System			1996	4,335						29
30	Ceiling Work, Insulation			1997	24,991						30
31	Backflow System & Sprinklers			1998	2,990						31
32	Roofing, Remodeling			1999	41,517						32
33	Drapes - Main Dining Area			2000	2,735						33
34	Windows - Dining Room			2000	3,620						34
35	Sprinkler Heads			2001	560						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: 07/01/14 Ending: 06/30/15

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						52
53	Chapel	1985	229,191						53
54	Draperies & Carpet	1986	4,252						54
55	Roof - New Shingles	2002	3,819						55
56	Garage Roof	2000	791						56
57	Generator and Pad	2005	65,163						57
58	Transformer, Blinds & Wallpaper	2005	10,802						58
59	Painting	2005	7,018						59
60	Painting and Carpet	2006	4,455						60
61	AC, Furnace, Windows, Doors	2006	12,121						61
62	Compressor, Lightling	2006	4,533						62
63	Disposal Unit, Architect Services	2006	13,451						63
64	Water Heater, Plumbing, Sprinkler	2007	33,058						64
65	Boiler, Furnace, AC, Windows	2007	206,728						65
66	Electrical Installation, Drapes & Transmitter	2007	38,918						66
67	Conference Room Addition	2007	107,533						67
68	Conference Room Addition	2008	129,172						68
69	IDPA Desk Review	2008	18,478						69
70	TOTAL (lines 4 thru 69)		$ 3,404,467	$		$	$	$	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: 07/01/14 Ending: 06/30/15

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	$		$	$	$	1
2	Asphalt	2008	1,500						2
3	Boiler	2008	43,995						3
4	Awning	2008	7,000						4
5	Compressor	2008	6,532						5
6	Sprinkler System	2008	8,539						6
7	Elevator	2008	4,833						7
8	Oxygen Room Improvements	2009	1,362						8
9	Office Flooring	2009	1,905						9
10	Carpet - E&F Wings	2010	1,548						10
11	Garbage Disposal	2010	1,558						11
12	Sump Pump & Electrical	2010	3,271						12
13	Sprinkler System-Closets	2010	16,600						13
14	Sprinkler System - Heads	2009	33,304						14
15	Sprinkler System - Upgrade to Quick Response	2010	17,244						15
16	20 Ton AC/Heating Unit	2010	24,915						16
17	Front Doors	2010	10,656						17
18	Flooring-Kitchen	2009	1,180						18
19	Roof	2009	40,945						19
20	Cabinets & Countertops	2010	1,309						20
21	Dining Room - Electrical Upgrades	2010	2,959						21
22	Dining Room Replacement Windows	2010	68,294						22
23	Dining Room Replacement Doors	2010	11,250						23
24	Dining Room - Roof Replacement	2010	39,246						24
25	Furnace & Radiator	2010	7,045						25
26	Door and Fire Alarm Pulls	2010	3,569						26
27	Landscaping	2010	42,099						27
28	Exit Panels and Lights	2010	4,042						28
29	Water Heater and Sink	2010	2,727						29
30	Sprinklers and Sink	2010	7,396						30
31	Paint	2010	4,849						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,826,139	$		$	$	$	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: 07/01/14 Ending: 06/30/15

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	$		$	$	$	1
2	Concrete driveway and parking lot	2011	17,084						2
3	Install sprinklers	2011	4,056						3
4	Install exhaust fan and hood	2011	10,400						4
5	Install emergency lights	2011	4,017						5
6	Replace gas water heater	2012	22,910						6
7	Install furnace	2012	3,813						7
8	Install new air conditioner	2012	7,308						8
9	Replace air conditioner condenser	2013	2,257						9
10	Install new carpet - F Wing	2013	849						10
11	Replace heat exchanger	2013	1,424						11
12	Purchase new computer server	2012	15,594						12
13	Purchase new floor scrubber	2013	791						13
14	Replace garbage disposal	2013	1,799						14
15	Install Wanderguard system	2013	4,863						15
16									16
17	Walk In Freezer	2014	3,607						17
18	Lighting Retrofit - 14 rooms	2014	12,174						18
19	Acquisition and connection of 3 Milnor commercial dryers	2014	27,529						19
20	Cabling for internet and new wireless system	2014	23,500						20
21									21
22	Lighting Retrofit - 14 rooms-Rebate	2015	(9,131)						22
23	Purchased (2) water holding tanks	2015	13,729						23
24	Room renovation - Rehab Wing - installation of new flooring,	2015	72,883						24
25	closets, valances, painting, acquisition of new furniture								25
26	and revamped plumbing in resident bathrooms								26
27									27
28									28
29									29
30	Depreciation			144,329		144,329			30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,067,595	$ 144,329		$ 144,329	$	$	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: 07/01/14 Ending: 06/30/15

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	$ 870,829	$ 52,392	$ 52,392	$		$	71
72	Current Year Purchases	36,622						72
73	Fully Depreciated Assets	141,317						73
74								74
75	TOTALS	$ 1,048,768	$ 52,392	$ 52,392	$		$	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				$	$	$	$		$	76
77	Local Transport	2004 Ford F150	2011	11,000	1,833	1,833				77
78										78
79										79
80	TOTALS			$ 11,000	$ 1,833	$ 1,833	$		$	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)	$ 5,162,702	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 198,554	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 198,554	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: 07/01/14 Ending: 06/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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.	/2016	$
13.	/2017	$
14.	/2018	$

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.

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/14 Ending: 06/30/15

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 [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 175,466	$		$ 175,466	1
2	Licensed Speech and Language Development Therapist		hrs			25,508			25,508	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			191,597	435		192,032	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				78,009		78,009	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					8,377			8,377	13
14	TOTAL			$		$ 400,948	$ 78,444		$ 479,392	14

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 **Report Period Beginning:** 07/01/14 **Ending:** 06/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/15 (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	$ 105,830	$	1
2	Cash-Patient Deposits	8,826		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	312,403		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,626		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)**	$ 487,685	$	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	4,750,781		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,081,314		16
17	Accumulated Depreciation (book methods)	(3,947,549)		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)**	$ 2,055,481	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,543,166	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 243,373	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,826		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	201,979		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,554		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	22,162		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 487,894	$	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)**	$ 487,894	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,055,272	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,543,166	$	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,383,176	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,383,176	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(363,904)	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)**	$ (363,904)	17
	B. Transfers (Itemize):		
18	**From Related Organization**	36,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 36,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,055,272	24 *

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/14 Ending: 06/30/15

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	$ 3,965,736	1
2	Discounts and Allowances for all Levels	(1,105,898)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,859,838	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,205,976	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,205,976	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	147,954	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,443	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 149,397	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,315	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,315	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)**	$ 4,216,526	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	977,920	31
32	Health Care	2,193,442	32
33	General Administration	1,196,481	33
	B. Capital Expense		
34	Ownership	212,587	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)***	$ 4,580,430	40
41	**Income before Income Taxes (line 30 minus line 40)****	(363,904)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (363,904)	43

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

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

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

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

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/14 Ending: 06/30/15

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,862	1,960	$ 62,323	$ 31.80	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	9,975	10,500	278,864	26.56	3
4	Licensed Practical Nurses	16,325	17,184	376,130	21.89	4
5	CNAs & Orderlies	55,204	58,110	662,118	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,528	3,714	85,393	22.99	8
9	Activity Director					9
10	Activity Assistants	5,770	6,074	79,354	13.06	10
11	Social Service Workers	1,818	1,914	34,175	17.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,803	18,740	216,000	11.53	15
16	Dishwashers					16
17	Maintenance Workers	5,232	5,507	99,692	18.10	17
18	Housekeepers	10,025	10,553	124,406	11.79	18
19	Laundry	6,621	6,969	62,105	8.91	19
20	Administrator	1,976	2,080	77,171	37.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,835	11,405	222,855	19.54	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)	146,974	154,710	$ 2,380,586 *	$ 15.39	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		6,000		36
37	Medical Records Consultant		1,264		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,735		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		5,175		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 17,174		49

C. CONTRACT NURSES

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/14 Ending: 06/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Dowell			$ 77,171
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,171

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	$ 210,761
Sackrider & Co		19,633
ADP		980
Legal adj to Zero		3,860
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 235,234

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,524
Unemployment Compensation Insurance	32,451
FICA Taxes	182,115
Employee Health Insurance	103,594
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	4,828
TOTAL (agree to Schedule V, line 22, col.8)	$ 419,512

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	4,332
Health Care Worker Background Check (Indicate # of checks performed)	1,140
Patient Background Checks	
PR	8,729
Dues & Subscriptions	302
License & Fees	(3,380)
Less: Public Relations Expense	(8,729)
Non-allowable advertising	(136)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,258

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	6,434
	46
Seminar Expense	2,320
	(3,801)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

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

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

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **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. $ **7,010**

(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 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 Line #	Sch 5 pg Col #	Sch 6 pg Line #	Adjustment Amount				
1009	PETTY CASH	105,830						1,009	1,009	CASH	105,830
1010	CASH IN BANK							1,100	1,100	ACCTS R	312,403
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBL	
1100	ACCOUNTS RECEIVABLE	312,403						1,110	1,110	ACCTS RECEIV-M/C	
1110	MEDICARE RECEIVABLES							1,125	1,125	ACCTS RECEIV-IPA	
1125	IPA INCOME RECEIVABLE							1,135	1,135	ACCTS RECEIV-IC	
1130	MEDICARE COST REPORT							1,140	1,140	UNAPPLIED CASH RECEIPTS	
1135	ACCOUNTS RECEIVABLE-IC							1,145	1,145	A/R SUSPENSE-REFUNDS	
1140	UNAPPLIED CASH RECEIPTS							1,200	1,200	PREPAID	60,626
1145	A/R SUSPENSE-REFUNDS							1,220	1,220	OTHER PREPAID EXPENSES	
1190	ACCRUED INTEREST REC							1,300	1,300	DIETARY INVENTORY	
1200	PREPAID INSURANCE	60,626						1,310	1,310	SUPPLIES INVENTORY	
1220	OTHER PREPAID EXPENSES							1,320	1,320	LINEN INVENTORY	
1300	FOOD INVENTORY							1,409	1,409	LAND	170,935
1310	SUPPLIES INVENTORY							1,450	1,450	FURNITU	1,081,314
1409	LAND	170,935						1,460			(886,522)
1450	FURNITURE & EQUIPMENT	1,081,314						1,475	1,475	BUILDIN	4,750,781
1460	ACCUM DEPR-FURN & EQU	-886,522						1,490	1,490	ACCUM I	(3,061,027)
1475	BUILDING & IMPROVEMEN	4,750,781						1,530	1,530	RESIDEN	8,826
1490	ACCUM DEPR-BUILDING	-3,061,027						1,550	1,550	LOAN FE	0
1530	RESIDENT FUNDS	8,826						1,551	1,551	LOAN FEES ADDED	
1550	LOAN FEES	0						1,850	1,850	INTERCC	0
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN	(243,373)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	0						2,100	2,100	ACCRUE	(65,282)
2010	ACCOUNTS PAYABLE	-243,373						2,100	2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-65,282						2,110	2,110	ACCRUE	(136,697)
2110	ACCRUED VACATION PAY	-136,697						2,120	2,120	U.C. TAX	0

Account	Description		
2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	-11,554	-11,554
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 PAYA	0	
2310	SALES TAX PAYABLE		
2320	IPA PAYMENTS PAYABLE	-22,162	
2350	REAL ESTATE TAX PAYAB	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	-8,826	
2600	MORTGAGE PAYABLE	0	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	-2,419,176	
2970	PROFIT/LOSS FOR PERIOD	363,904	
3007.1	PATIENT DAYS-PRIVATE	12,448	

2,125	2,125	FICA TA:	(11,554)
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 REF	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETE	
2,246	2,250	401K W/I	
2,250			
2,260	2,260	WAGE G.	
2,300	2,300	ACCRUE	0
2,320	2,320	IPA PAYI	(22,162)
2,350	2,350	REAL ES	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEI	
2,512	2,512	DUE TO I	(8,826)
2,600	2,600	LASALLI	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEI	
2,720	2,720	RETAINE	(2,419,176)
		net incom	363,904
		balance	0
3,007			

3007.2		PATIENT DAYS-IPA	10,674					3,007
3007.3		PATIENT DAYS-MEDICARE	2,209					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 &	-3,940,636	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-PRIVA	-21,195	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	-147,954	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-1,205,976	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	1,105,898	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/EXPEN:	0		0	0	0	0			3,590
3580		12	MANAGEMENT FEES			0	0	0	0			3,595
3590		1	EQUIPMENT RENTAL	-3,905		0	0	0	0			3,600
3595		21	RESIDENT TRANSPORTATI	-1,443		0	0	0	0			4,110
3600		21	MISC INCOME	0		0	0	0	0			4,111
4110			GENERAL & ADMINIST WA	203,566	222,855	21	1	17	0			4,115
4111			ADMINISTRATOR WAGES	77,171	77,171	17	1	0	0			4,120
4115			VACATION & SICK - G&A	19,289		21	1	0	0			4,121
4120	4475		EMPLOYEE BENEFITS	4,828	419,512	22	3	0	0			4,130
4125			EMPLOYEE HEPETITIS VA(	0		22	3	0	0			4,135
4130			EMPLOYEE SCHOLORSHIP	0		21	1	0	0			4,250
4135			EMPLOYEE SCHOLORSHIP	0		23	3	0	0			4,255
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260
4250	4255		OFFICE SUPPLIES	24,049	24,049	21	2	0	0			4,275
4260			TELEPHONE	9,943	9,943	21	3	0	0			4,276
4275			TRAINING & EMPLOYEE D	2,636	2,636	23	3	16	0	**		4,280
4280			GENERAL TRAVEL	6,434	8,800	24	3	16	0			4,281
4281			MEAL EXPENSE FOR TRAV	46		24	3	19	0			4,285
4285			EDUCATION & SEMINAR	2,320		24	3	19	-3,801	***		4,289
4290			HELP WANTED ADVERTISI	4,332	74,909	20	3	0	0		-57,488	4,290
4291			PROMOTIONAL ADVERTIS	6,298		20	3	25	-6,298			4,291
4292			PUBLIC RELATIONS	8,729		20	3	25	-8,729			4,292
4300			LICENSES & FEES	54,108		20	3	17	0			4,300
4310			DUES & SUBSCRIPTIONS	302		20	3	17	-136			4,310
4320			CONTRIBUTIONS	0		27	3	20	0			4,320
4350			PROFESSIONAL FEES	24,473	235,234	19	3	22	-3,860			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 CONSI	1,264		10	3	0	0	4,364
4363	PHARMACIST FEES	4,735		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	5,175	5,175	12	3	0	0	4,383
4370	TV RENTAL	1,464		35	3	5	0	4,390
4380	INCOME TAXES		24,058	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,140		20	3	26	0	4,401
4400	PAYROLL TAXES	206,556		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,010		22	3	0	0	4,420
4410	GROUP INSURANCE	103,594		22	3	0	0	4,430
4420	LIABILITY INSURANCE	97,314	97,314	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	96,524		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	210,761		19	3	34	0 **	4,460
4460	BAD DEBTS	24,000		27	3	24	-24,000	4,461
4470	LOST ITEMS-RESIDENTS	58		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	12,421	13,885	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	92,353	99,692	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	7,339		6	1	0	0	4,510
5130	ELECTRIC	81,990	144,973	5	3	0	0	4,600
5131	NATURAL GAS	35,881		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	27,102		5	3	0	0	5,130
5134	TRASH COLLECTION	12,302	52,745	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	5,876	56,063	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	50,187		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	40,443		6	3	0	0	5,140
5210	DIETARY WAGES	201,889	216,000	1	1	0	0	5,160
5220	DIETARY SICK & VAC	14,111		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	171,919	164,909	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	4,327	12,084	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	1,942		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	5,815		1	2	0	0	5,260
5295	MEAL CREDIT	-7,010		2	2	0	0	5,270
5310	LAUNDRY WAGES	59,055	62,105	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,050		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	3,439	8,890	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	5,451		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	117,315	124,406	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VA	7,091		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	37,999	36,053	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	-1,946		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,464,828	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	257,616		10	1	0	0	6,020
6030	DON WAGES	62,323		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	21,248		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	355,050		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICA	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	21,080		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICA	631,326		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	30,792		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 WA	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 RE	0		0	0	0	0	6,295
6270	REHAB WAGES	78,187		10	1	0	0	6,390
6275	REHAB SICK & VAC	7,206		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	16,693	111,687	10	2	0	0	7,281
6295	NURSING SUPPLIES	88,374		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	6,620		10	2	0	0	7,391
6490	NURSING OTHER	276	6,275	10	3	0	0	7,393
7280	DRUG PURCHASES	67,061	78,444	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	10,948		39	2			7,540
7380	LABORATORY SERVICES	8,377	400,948	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	73,885	79,354	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	5,469		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	6,556	6,556	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	191,597		39	3	0	0 ***	7,890
7660	PT SUPPLIES	435		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	31,900	34,175	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	2,275		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	175,466		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	25,508		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	148	148	32	3	14	-1,315	
8130	DEPRECIATION	198,554	198,554	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-1,315		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		4,579,115	4,580,430					
			1,315					
GRAND TOTALS		363,904					-48,139	
		(NET INCOME)						
		0						

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	12,448	12,448
IPA	10,674	10,674
medicare	2,209	2,209
		25,331

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BT

BT

3,007 PATIENT 12,448

3,007	PATIENT	10,674
3,007	PATIENT	2,209
		0
3,010	BASIC CI	(3,940,636)
3,020	BASIC CI	0
3,030	BASIC CI	0
		0
		0
		0
		0
3,080	NURSING	(21,195)
3,081	NURSING	0
3,082	NURSING	0
3,083	NURSING	0
3,100	DRUGS-M	(147,954)
		0
3,110	PHYSICA	(1,205,976)
		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	1,050,982

3,520	RENT IN(	0
3,530	BEAUTY	0
		0
3,570	VENDIN(	0
3,590	EQUIPMI	(3,905)
3,595	RESIDEN	(1,443)
3,600	MISC IN(	0
4,110	G&A WA	203,566
4,111	ADMINIS	77,171
4,115	G&A PT(	19,289
4,120	EMPLOY	4,772
4,130	EMPLOY	0
4,135	EMPLOY	0
4,250	OFFICE S	12,343
4,255	POSTAGI	2,455
4,260	TELEPH(	9,943
4,275	TRAININ	2,636
		0
4,280	GENERA	6,434
4,281	MEAL EX	46
4,285	EDUCAT	2,186
4,289	MEETIN(	134
4,290	HELP WA	4,332
4,291	PROMOT	6,298
4,292	PUBLIC I	8,729
4,300	LICENSE	54,108
4,310	DUES & S	302
4,320	CONTRIE	0
4,350	PROFESS	24,473
4,355	MEDICA	6,000
		1,264
		4,735

4,364	SOCIAL S	5,175
4,370	TV RENT	1,464
4,383	BACKGR	1,140
4,390	OTHER T	0
4,400	PAYROL	206,556
4,401	PAYROL	8,010
4,410	GROUP I	103,594
4,420	LIABILIT	97,314
4,430	WORKM	93,476
4,435	W/C-FIRS	289
4,436	DRUG TE	2,759
4,450	MANAGE	210,761
4,460	BAD DEE	24,000
4,461	BAD DEE	54,916
4,470	LOST ITE	58
4,475	UNIFORM	56
4,486	SERVICE	21,879
4,490	MISC EX	962
4,496	MISC. M.	9,251
4,510	REAL ES	0
4,600	LEASED	12,421
5,110	MAINTE	92,353
5,120	MAINTE	7,339
5,130	ELECTRI	81,990
5,131	NATURA	35,881
5,133	WATER a	27,102
5,134	TRASH C	12,302
5,140	PROP/PL	5,876
5,160	GENERA	50,187
5,165	MAINTE	18,564
5,210	DIETARY	201,889
5,220	DIETARY	14,111
5,248	FOOD PU	170,957

5,250	SUPPLIE	4,327
5,260	REPLACI	1,942
5,270	KITCHEN	5,815
5,295	MEAL IN	(7,010)
5,310	LAUNDR	59,055
5,340	LAUNDR	3,050
5,370	REPLACI	3,439
		0
5,390	SUPPLIE	5,451
5,410	HOUSEK	117,315
5,440	HOUSEK	7,091
5,480	SUPPLIE	37,999
5,490	SUPPLIE	(1,946)
6,020	RN WAG	257,616
6,030	DON WA	62,323
6,035	ADON W	0
6,040	RN PTO &	21,248
6,120	LPN WAG	355,050
6,140	LPN PTO	21,080
6,220	AIDES W	631,326
6,240	AIDES PT	30,792
		0
		0
		0
6,270	REHAB W	78,187
6,275	REHAB P	7,206
6,290	NURSING	16,693
6,295	NURSING	88,374
6,390	REPLACI	6,620
6,490	OTHER	276

7,280	DRUG PU	67,061
7,281	DRUG PU	10,948
7,380	LABORA	4,304
7,390	X-RAY S	1,777
		2,296
7,510	ACTIVIT	73,885
7,540	ACTIVIT	5,469
7,590	ACTIVIT	6,556
7,620	PHYSICA	191,597
7,660	P.T. SUPI	435
7,710	SOCIAL S	31,900
7,720	SOCIAL S	2,275
7,730	SOCIAL S	0
7,740	OCCUPA	175,466
7,770	SPEECH	25,508
7,820	BEAUTIC	0
		0
		0
8,120	INTERES	148
		0
8,130	DEPRECI	198,554
		0
9,510	INTERES	(1,315)
9,520	MISC NO	0
4,220		0
8,100		0
9,702		0
5,230		0
		363,904

Expenses Fixed Assets

0

Burnsides Community Health Center
2015 Cost Report
Supplemental Schedules

1. Schedule V - Line 10a to Line 39 - Reclassifications

Line Item		
Purchased Drugs and Medications	$	78,009
Purchased Hospital Services		2,296
Purchased Laboratory Services		4,304
Purchased Radiology Services		1,777
Amount Reclassified to Line 39	$	86,386

2. Schedule V - Line 20 to Line 42 - Reclassification

Line Item		
Provider Participation Fee	$	57,488