FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 07/01/15 to 06/30/16 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: 07/01/15 Ending: 06/30/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	34,770	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	95	TOTALS	95	34,770	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	9,618	10,932	2,431	22,981	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,618	10,932	2,431	22,981	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.09%

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 95 and days of care provided 2,431

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: 07/01/15 Ending: 06/30/16

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	194,328	10,009		204,337		204,337		204,337			1
2	Food Purchase		145,707		145,707		145,707		145,707			2
3	Housekeeping	137,819	34,204		172,023		172,023		172,023			3
4	Laundry	47,606	7,317		54,923		54,923		54,923			4
5	Heat and Other Utilities			141,817	141,817		141,817		141,817			5
6	Maintenance	85,903	46,306	51,797	184,006		184,006		184,006			6
7	Other (specify):*											7
8	TOTAL General Services	465,656	243,543	193,614	902,813		902,813		902,813			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,350,115	102,181	20,581	1,472,877		1,472,877		1,472,877			10
10a	Therapy		134,762	432,595	567,357	(146,624)	420,733		420,733			10a
11	Activities	69,691	5,305		74,996		74,996		74,996			11
12	Social Services	33,176		4,677	37,853		37,853		37,853			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,452,982	242,248	463,853	2,159,083	(146,624)	2,012,459		2,012,459			16
	C. General Administration											
17	Administrative	76,694			76,694		76,694		76,694			17
18	Directors Fees											18
19	Professional Services			219,207	219,207	(4,583)	214,624	(7,982)	206,642			19
20	Dues, Fees, Subscriptions & Promotions			79,838	79,838	(52,155)	27,683	(17,686)	9,997			20
21	Clerical & General Office Expenses	200,010	23,256	10,791	234,057		234,057		234,057			21
22	Employee Benefits & Payroll Taxes			431,775	431,775		431,775		431,775			22
23	Inservice Training & Education			4,828	4,828		4,828		4,828			23
24	Travel and Seminar			4,839	4,839		4,839		4,839			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			99,045	99,045	4,583	103,628		103,628			26
27	Other (specify):*			24,000	24,000		24,000	(24,000)				27
28	TOTAL General Administration	276,704	23,256	874,323	1,174,283	(52,155)	1,122,128	(49,668)	1,072,460			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,195,342	509,047	1,531,790	4,236,179	(198,779)	4,037,400	(49,668)	3,987,732			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: 07/01/15 Ending: 06/30/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			190,301	190,301		190,301		190,301			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			214	214		214	(4)	210			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,210	17,210		17,210		17,210			35
36	Other (specify):*											36
37	**TOTAL Ownership**			207,725	207,725		207,725	(4)	207,721			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					146,624	146,624		146,624			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					52,155	52,155		52,155			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					198,779	198,779		198,779			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,195,342	509,047	1,739,515	4,443,904		4,443,904	(49,672)	4,394,232			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: 07/01/15 Ending: 06/30/16

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	(4)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,982)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)			24
25	Fund Raising, Advertising and Promotional	(17,686)			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)**	$ (49,672)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (49,672)		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

Burnsides Community Hlth Ctr

ID# 0007153

Report Period Beginning: 07/01/15

Ending: 06/30/16

	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		(7,982)	19	22
23				23
24		(24,000)	27	24
25		(17,686)	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	(49,668)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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	(7,982)	0	0	0	0	0	0	0	0	0	0	(7,982)	19
20	Fees, Subscriptions & Promotions	(17,686)	0	0	0	0	0	0	0	0	0	0	(17,686)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	27
28	**TOTAL General Administration**	(49,668)	0	0	0	0	0	0	0	0	0	0	(49,668)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(49,668)	0	0	0	0	0	0	0	0	0	0	(49,668)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	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	(4)	0	0	0	0	0	0	0	0	0	0	(4)	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**	(4)	0	0	0	0	0	0	0	0	0	0	(4)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(49,672)	0	0	0	0	0	0	0	0	0	0	(49,672)	45

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/15 Ending: 06/30/16

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						
(Community Board - no individual						
ownership exists)						

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: 07/01/15 Ending: 06/30/16

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	No compensation is paid								$		1
2	to any Board Member										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: 07/01/15 Ending: 06/30/16

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: 07/01/15 Ending: 06/30/16

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			Line of Credit							214	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 214	9
	B. Non-Facility Related*											
10	Interest Income										(4)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4)	14
15	TOTALS (line 9+line14)						$	$			$ 210	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: 07/01/15 Ending: 06/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 David M Underwood

TELEPHONE 309-823-7135 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 07/01/15 Ending: 06/30/16

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	$ 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: 07/01/15 Ending: 06/30/16

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	95		1963	1963	$ 823,909	$		$	$	$	4
5			1995	1995	1,100,822						5
6			2002	2002	3,982						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: 07/01/15 Ending: 06/30/16

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: 07/01/15 Ending: 06/30/16

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: 07/01/15 Ending: 06/30/16

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	77,982						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									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,072,694	$		$	$	$	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: 07/01/15 Ending: 06/30/16

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 12C, Carried Forward		$ 4,072,694	$		$	$	$	1
2									2
3	Install new air handler and controllers	2016	68,013						3
4	Replace kitchen air conditioner	2016	7,747						4
5	Resurface parking lot	2016	6,500						5
6	Install (28) new sinks and mounting brackets	2016	12,230						6
7	Repipe power air handler	2016	2,887						7
8	Rebuidl damaged dining room wall	2016	6,704						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	Depreciation			142,419		142,419			30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,176,775	$ 142,419		$ 142,419	$	$	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: 07/01/15 Ending: 06/30/16

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	$ 907,451	$ 47,882	$ 47,882	$		$	71
72	Current Year Purchases	3,594						72
73	Fully Depreciated Assets	141,317						73
74								74
75	TOTALS	$ 1,052,362	$ 47,882	$ 47,882	$		$	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						77
78										78
79										79
80	TOTALS			$ 11,000	$	$	$		$	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)	$ 5,275,476	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 190,301	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 190,301	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: 07/01/15 Ending: 06/30/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 18,702 Description: Dishwasher and copiers
(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: 07/01/15 Ending: 06/30/16

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.

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$		$ 149,992	$		$ 149,992	1
2	Licensed Speech and Language Development Therapist		hrs			28,158			28,158	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			242,461	122		242,583	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				134,640		134,640	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					11,984			11,984	13
14	TOTAL			$		$ 432,595	$ 134,762		$ 567,357	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:** 07/01/15 **Ending:** 06/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/16 **(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	$ 26,728	$	1
2	Cash-Patient Deposits	10,050		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	511,598		3
4	Supply Inventory (priced at FIFO)	30,634		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,716		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)**	$ 598,726	$	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	4,859,961		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,084,908		16
17	Accumulated Depreciation (book methods)	(4,136,630)		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)**	$ 1,979,174	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,577,900	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 322,009	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,050		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,384		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,382		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	19,199		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 566,024	$	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)**	$ 566,024	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,011,876	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,577,900	$	48

***(See instructions.)**

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/15 Ending: 06/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,055,272	1
2	Restatements (describe):		2
3	**Adjustment to 2015 Net Income**	23,063	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,078,335	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(291,459)	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)**	$ (291,459)	17
	B. Transfers (Itemize):		
18	**From Related Organization**	225,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 225,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,011,876	24 *

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

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 3,907,879	1
2	Discounts and Allowances for all Levels	(1,330,551)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,577,328	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,328,357	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,328,357	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	245,829	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	927	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 246,756	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4	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)**	$ 4,152,445	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	902,813	31
32	Health Care	2,159,083	32
33	General Administration	1,174,283	33
	B. Capital Expense		
34	Ownership	207,725	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)***	$ 4,443,904	40
41	**Income before Income Taxes (line 30 minus line 40)****	(291,459)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (291,459)	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: 07/01/15 Ending: 06/30/16

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	1,865	1,984	$ 62,849	$ 31.68	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,434	8,972	249,889	27.85	3
4	Licensed Practical Nurses	14,433	15,354	351,437	22.89	4
5	CNAs & Orderlies	48,102	51,172	603,004	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,355	3,569	82,936	23.24	8
9	Activity Director					9
10	Activity Assistants	4,610	4,904	69,691	14.21	10
11	Social Service Workers	1,700	1,808	33,176	18.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,527	16,518	194,328	11.76	15
16	Dishwashers					16
17	Maintenance Workers	4,706	5,006	85,903	17.16	17
18	Housekeepers	10,461	11,129	137,819	12.38	18
19	Laundry	4,898	5,211	47,606	9.14	19
20	Administrator	1,955	2,080	76,694	36.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,954	9,526	200,010	21.00	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)	129,000	137,233	$ 2,195,342 *	$ 16.00	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		939		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,689		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		4,677		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,305		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		15,605		52
53	TOTAL (lines 50 - 52)		$ 15,605		53

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/15 Ending: 06/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Dowell	Administrator	0	$ 76,694
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,694

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	$ 204,873
Sackrider & Co		500
ADP		1,244
Cincinnati Insurance		4,583
Diamond Financial		25
Legal adj to Zero		7,982
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 219,207

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,886
Unemployment Compensation Insurance	25,971
FICA Taxes	167,944
Employee Health Insurance	155,243
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	1,731
TOTAL (agree to Schedule V, line 22, col.8)	$ 431,775

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	6,766
Health Care Worker Background Check	
(Indicate # of checks performed)	920
Patient Background Checks	
PR	9,470
Dues & Subscriptions	400
License & Fees	1,911
Less: Public Relations Expense	(9,470)
Non-allowable advertising	(0)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,997

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,474
	0
Seminar Expense	1,365
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,839

**See instructions.

Facility Name & ID Number Burnsides Community Hlth Ctr # 0007153 Report Period Beginning: 07/01/15 Ending: 06/30/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

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

(3) Did the nursing home make political contributions or payments to a politica
action organization? 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? If YES, what is the capacity?

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

(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 fo
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 Departmen
during this cost report period. $ 52,155
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ 4,520

(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 fo
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?
Firm Name:

(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 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount		
1009			PETTY CASH	26,728							
1010			CASH IN BANK								
1040			CASH IN BANK-PAYROLL								
1100			ACCOUNTS RECEIVABLE	511,598							
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	19,716							
1220			OTHER PREPAID EXPENSES								
1300			FOOD INVENTORY	30,634							
1310			SUPPLIES INVENTORY								
1409			LAND	170,935							
1450			FURNITURE & EQUIPMENT	1,084,908							
1460			ACCUM DEPR-FURN & EQUIP	-933,818							
1475			BUILDING & IMPROVEMENTS	4,859,961							
1490			ACCUM DEPR-BUILDING	-3,202,812							
1530			RESIDENT FUNDS	10,050							
1550			LOAN FEES	0							
1560			REAL ESTATE TAX ESCROW								
1575			REIMBURSABLE PURCHASES								
1850			INTRACOMPANY	0							
2010			ACCOUNTS PAYABLE	-322,009							
2095			BONUSES PAYABLE								
2100			ACCRUED PAYROLL	-74,156							
2110			ACCRUED VACATION PAY	-133,228							
2120			UC TAXES PAYABLE								
2125			FICA TAX PAYABLE	-7,382	-7,382						
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	-19,199							
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	-10,050							
2600			MORTGAGE PAYABLE	0							
2650			EQUIPMENT LOAN PAYABLE								
2695			CURRENT PORTION LT DEBT								
2696			DEFERRED INCOME TAXES								
2710			COMMON STOCK								
2720			RETAINED EARNINGS	-2,303,335							
2970			PROFIT/LOSS FOR PERIOD	291,459							
3007.1			PATIENT DAYS-PRIVATE	10,932							
3007.2			PATIENT DAYS-IPA	9,618							
3007.3			PATIENT DAYS-MEDICARE	2,431							
3007.4			PATIENT DAYS-CONVERSION								
3007.5			PATIENT DAYS-LICENSED								
3007.6			PATIENT DAYS-TOTAL								
3010		1	BASIC CHARGE-PRIVATE & VA	-3,885,152		0	0	0	0		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		
3020		1	BASIC CHARGE-IPA	0		0	0	0	0		
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0		
3035		4	DAY CARE/HOME CARE			0	0	0	0		
3040		1	LIGHT NURSING CARE	0		0	0	0	0		
3050		1	MEDIUM NURSING CARE			0	0	0	0		
3060		1	HEAVY NURSING CARE			0	0	0	0		
3061		1	SKILLED NURSING CARE								
3080		1	NURSING SUPPLIES-PRIVATE	-17,780		0	0	0	0		
3081		1	NURSING SUPPLIES-IPA			0	0	0	0		
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0		
3083		1	NURSING SUPPLIES MED PT B								
3100		17	DRUGS	-245,829		0	0	0	0		
3101		17	DRUGS-OTHER								
3110		6	PT-PRIVATE	-1,328,357		0	0	0	0		
3111		6	PT-IPA			0	0	0	0		
3112		6	PT-MEDICARE PART A			0	0	0	0		
3113		6	PT-MEDICARE PART B			0	0	0	0		
3130		1	PUBLIC AID ASSESSMENT INC								
3140		19	LABORATORY INCOME			0	0	0	0		
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		
3151		6	SPEECH/OT-IPA			0	0	0	0		
3152		6	SPEECH/OT-MED PART A			0	0	0	0		
3153		6	SPEECH/OT MED PART B								
3410		2	IPA DISCOUNTS	1,330,551		0	0	0	0		
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0		
3420		2	MEDICARE DISCOUNTS			0	0	0	0		
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0		
3520		16	RENT INCOME	0		6	0	6	0		
3530		13	BEAUTY SHOP	0		0	0	0	0		
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0		
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0		
3580		12	MANAGEMENT FEES			0	0	0	0		
3590		1	EQUIPMENT RENTAL	-4,947		0	0	0	0		
3595		21	RESIDENT TRANSPORTATION	-927		0	0	0	0		
3600		21	MISC INCOME	0		0	0	0	0		
4110			GENERAL & ADMINIST WAGES	180,153	200,010	21	1	17	0		
4111			ADMINISTRATOR WAGES	76,694	76,694	17	1	0	0		
4115			VACATION & SICK - G&A	19,857		21	1	0	0		
4120	4475		EMPLOYEE BENEFITS	1,731	431,775	22	3	0	0		
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0		
4130			EMPLOYEE SCHOLORSHIP WA	0		21	1	0	0		
4135			EMPLOYEE SCHOLORSHIP CO	0		23	3	0	0		
4220			DIRECTORS FEES	0	0	18	3	0	0		
4250	4255		OFFICE SUPPLIES	23,256	23,256	21	2	0	0		
4260			TELEPHONE	10,791	10,791	21	3	0	0		
4275			TRAINING & EMPLOYEE DEVL	4,828	4,828	23	3	16	0	**	
4280			GENERAL TRAVEL	3,474	4,839	24	3	16	0		
4281			MEAL EXPENSE FOR TRAVEL	0		24	3	19	0		
4285			EDUCATION & SEMINAR	1,365		24	3	19	0	***	
4290			HELP WANTED ADVERTISING	6,766	79,838	20	3	0	0		-52,155
4291			PROMOTIONAL ADVERTISING	8,216		20	3	25	-8,216		
4292			PUBLIC RELATIONS	9,470		20	3	25	-9,470		
4300			LICENSES & FEES	54,066		20	3	17	0		
4310			DUES & SUBSCRIPTIONS	400		20	3	17	0		
4320			CONTRIBUTIONS	0		27	3	20	0		
4350			PROFESSIONAL FEES	12,793	219,207	19	3	22	-7,982		
4355			MEDICAL DIRECTOR	6,000	6,000	9	3	0	0		
4360			UTILIZATION REVIEW	0		10	3	0	0		
4361			OTHER PHYSICIAN FEES			39	3	0	0		
4362			MEDICAL RECORDS CONSULT	939		10	3	0	0		
4363			PHARMACIST FEES	3,689		10	3	0	0		
4364			SOC SERV/ACT CONSULT	4,677	4,677	12	3	0	0		
4370			TV RENTAL	-1,492		35	3	5	0		
4380			INCOME TAXES		24,000	27	3	26	0		
4383			BACKGROUND CHECKS	920		20	3	26	0		
4400			PAYROLL TAXES	185,954		22	3	0	0		
4401			PAYROLL TAXES ADMINIST	7,961		22	3	0	0		
4410			GROUP INSURANCE	155,243		22	3	0	0		
4420			LIABILITY INSURANCE	99,045	99,045	26	3	0	0		
4425			INSURANCE-OWNERS			22	3	21	0		
4430			WORKMENS COMP INSURANCE	80,886		22	3	0	0		
4450			CENTRAL OFFICE FEES	206,414		19	3	34	0	**	
4460			BAD DEBTS	24,000		27	3	24	-24,000		
4470			LOST ITEMS-RESIDENTS	0		27	3	0			
4490			MISCELLANEOUS	0		27	3	0	0		
4510			REAL ESTATE TAXES	0	0	33	3	0	0		
4600			LEASED EQUIPMENT	18,702	17,210	35	3	16	0		
5110			MAINTENANCE SALARIES	78,177	85,903	6	1	0	0		
5120			MAINTENANCE SICK & VAC	7,726		6	1	0	0		
5130			ELECTRIC	87,400	141,817	5	3	0	0		
5131			NATURAL GAS	27,773		5	3	0	0		
5132			HEATING & DEISEL OIL			5	3	0	0		
5133			WATER & SEWER	26,644		5	3	0	0		
5134			TRASH COLLECTION	7,794	51,797	6	3	0	0		
5140			PROPERTY PLANT REPLACEM	8,108	46,306	6	2	0	0		
5160			GENERAL REPAIR & MAINT	38,198		6	2	0	0		
5165			MAINTENANCE CONTRACTS	44,003		6	3	0	0		
5210			DIETARY WAGES	181,781	194,328	1	1	0	0		
5220			DIETARY SICK & VAC	12,547		1	1	0	0		
5240			SALES TAX			2	3	13	0		
5248			FOOD PURCHASES	150,227	145,707	2	2	0	0		
5250			SUPPLIES-DISHWASHING	4,295	10,009	1	2	0	0		
5260			DIETARY REPLACEMENT	1,533		1	2	0	0		
5270			KITCHEN SUPPLIES-PAPER	4,181		1	2	0	0		
5295			MEAL CREDIT	-4,520		2	2	0	0		
5310			LAUNDRY WAGES	45,248	47,606	4	1	0	0		
5340			LAUNDRY SICK & VAC	2,358		4	1	0	0		
5370			LAUNDRY REPLACEMENT	2,174	7,317	4	2	0	0		
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		
5390			LAUNDRY SUPPLIES	5,143		4	2	0	0		
5410			HOUSEKEEPING WAGES	130,249	137,819	3	1	0	0		
5440			HOUSEKEEPING SICK & VAC	7,570		3	1	0	0		
5480			HOUSEKEEPING SUPPLIES	34,504	34,204	3	2	0	0		
5490			HOUSEKEEPING SUPPLIES-PP	-300		3	2	0	0		
6010			RN WAGES-MEDICARE		1,350,115	10	1	0	0		
6020			RN WAGES-NON MEDICARE	228,197		10	1	0	0		
6030			DON WAGES	62,849		10	1	0	0		
6035			ADON	0		10	1	0	0		
6040			RN SICK & VACATION	21,692		10	1	0	0		
6110			LPN WAGES-MEDICARE	330,182		10	1	0	0		
6120			LPN WAGES-NON MEDICARE	0		10	1	0	0		
6130			LPN WAGES OTHER			10	1	0	0		
6140			LPN SICK & VACATION	21,255		10	1	0	0		
6210			AIDE WAGES-MEDICARE			10	1	0	0		
6220			AIDE WAGES-NON MEDICARE	571,130		10	1	0	0		
6230			WARD CLERKS			10	1	0	0		
6240			AIDE VACATION & SICK	31,874		10	1	0	0		
6245			CONTRACT NURSES-RN	0		10	3	0	0		
6246			CONTRACT NURSES-LPN	0		10	3	0	0		
6247			CONTRACT NURSES-AIDES	15,605		10	3	0	0		
6250			NURSE AIDE TRAINING WAGES	0	0	13	1	0	0		
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0		
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0		
6270			REHAB WAGES	75,016		10	1	0	0		
6275			REHAB SICK & VAC	7,920		10	1	0	0		
6280			NURSING DEPT EDUCATION			23	3	0	0		
6290			NURSING SUPPLIES	16,280	102,181	10	2	0	0		
6295			NURSING SUPPLIES	80,936		10	2	0	0		
6390			REPLACEMENT-NURSING	4,965		10	2	0	0		
6490			NURSING OTHER	348	20,581	10	3	0	0		
7280			DRUG PURCHASES	131,222	134,762	39	2	0	0	***	
7281			DRUG PURCHASES-OTHER	3,418		39	2				
7380			LABORATORY SERVICES	11,984	432,595	39	3	0	0		
7410			HOME HEALTH SALARY			39	1	0	0		
7440			HOME HEALTH SICK & VAC			39	1	0	0		
7450			HOME HEALTH EXPENSES			39	3	0	0		
7510			ACTIVITES WAGES	64,681	69,691	11	1	0	0		
7540			ACTIVITIES SICK & VAC	5,010		11	1	0	0		
7590			ACTIVITIES SUPPLIES	5,305	5,305	11	2	0	0		
7595			ACTIVITIES FEES	0	0	11	3	0	0		
7610			PT WAGES			39	1	0	0		
7611			PT SICK & VACATION			39	1	0	0		
7620			PT FEES	242,461		39	3	0	0	***	
7660			PT SUPPLIES	122		39	2	0	0		
7710			SOCIAL SERVICE WAGES	30,318	33,176	12	1	0	0		
7720			SOCIAL SERVICE SICK & VAC	2,858		12	1	0	0		
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		
7740			OT FEE	149,992		39	3	0	0	***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		
7770			SPEECH THERAPY FEE	28,158		39	3	0	0	***	
7800			BEAUTICIAN WAGES		0	40	1	0	0		
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	214	214	32	3	14	-4		
8130			DEPRECIATION	190,301	190,301	30	3	9	0		
8150			LOAN FEE AMORTIZATION	0		32	3	0	0		0
9510			INTEREST INCOME	-4		32	0	10	0		
9520			MISC NON-OPERATING INCOM	0		0	0	0	0		
9700			INCOME TAXES	0		0	0	0	0		
				4,443,900	4,443,904						
					4						
GRAND TOTALS				291,459					-49,672		
				(NET INCOME)							
				0							

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	10,932	10,932

1,009	1,009	CASH	26,728
1,100	1,100	ACCTS RE	511,598
1,101	1,101	ALLOW. FOR UNCOLLECTIBLES	
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 I	19,716
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY I	30,634
1,310	1,310	SUPPLIES	
1,320	1,320	LINEN INVENTORY	
1,409	1,409	LAND	170,935
1,450	1,450	FURNITUF	1,084,908
1,460			(933,818)
1,475	1,475	BUILDING:	4,859,961
1,490	1,490	ACCUM DI	(3,202,812)
1,530	1,530	RESIDENT	10,050
1,550	1,550	LOAN FEE	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCO	0
2,010	2,010	ACCOUNT	(322,009)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUED	(74,156)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUED	(133,228)
2,120	2,120	U.C. TAXE	0
2,125	2,125	FICA TAXE	(7,382)
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 REFUND	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETERIA	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GA	
2,300	2,300	ACCRUED	0
2,320	2,320	IPA PAYM	(19,199)
2,350	2,350	REAL EST	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO R	(10,050)
2,600	2,600	LASALLE I	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEBT	
2,720	2,720	RETAINED	(2,303,335)
		net income	291,459
		balance	0

3,007	3,007	PATIENT D	10,932
3,007	3,007	PATIENT D	9,618
3,007	3,007	PATIENT D	2,431
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CH/	(3,885,152)
3,020	3,020	BASIC CH/	0
3,030	3,030	BASIC CH/	0
3,040			0
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING	(17,780)
3,081	3,081	NURSING	0
3,082	3,082	NURSING	0
3,083	3,083	NURSING	0
3,100	3,100	DRUGS-M	(245,829)
3,101			0
3,110	3,110	PHYSICAL	(1,328,357)
3,111			0
3,112	3,112	PHYSICAL	0
3,113	3,113	PHYSICAL	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT THE	0
3,153	3,153	ST/OT THE	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHE	0
3,411	3,411	MEDICARE	0
3,420	3,420	MEDICARE	1,277,429
3,500			
3,520	3,520	RENT INC	0
3,530	3,530	BEAUTY S	0
3,560			0
3,570	3,570	VENDING	0
3,590	3,590	EQUIPME	(4,947)
3,595	3,595	RESIDENT	(927)
3,600	3,600	MISC INC	0
4,110	4,110	G&A WAG	180,153
4,111	4,111	ADMINIST	76,694
4,115	4,115	G&A PTO	19,857
4,120	4,120	EMPLOYE	1,752
4,121			
4,130	4,130	EMPLOYE	0
4,135	4,135	EMPLOYE	0
4,250	4,250	OFFICE SI	12,756
4,255	4,255	POSTAGE	2,728
4,260	4,260	TELEPHOI	10,791
4,275	4,275	TRAINING	4,828
4,276			0
4,280	4,280	GENERAL	3,474
4,281	4,281	MEAL EXP	0
4,285	4,285	EDUCATIC	679
4,289	4,289	MEETINGS	686
4,290	4,290	HELP WAI	6,766
4,291	4,291	PROMOTI	8,216
4,292	4,292	PUBLIC RI	9,470
4,300	4,300	LICENSE &	54,066
4,310	4,310	DUES & SI	400
4,320	4,320	CONTRIBU	0
4,350	4,350	PROFESS	12,793
4,355	4,355	MEDICAL	6,000
4,362			939
4,363			3,689
4,364	4,364	SOCIAL SI	4,677
4,370	4,370	TV RENTA	(1,492)
4,383	4,383	BACKGRC	920
4,390	4,390	OTHER TA	0
4,400	4,400	PAYROLL	185,954
4,401	4,401	PAYROLL	7,961
4,410	4,410	GROUP IN	155,243
4,420	4,420	LIABILITY	99,045
4,430	4,430	WORKMAI	78,111
4,435	4,435	W/C-FIRST	71
4,436	4,436	DRUG TES	2,704
4,450	4,450	MANAGEN	206,414
4,460	4,460	BAD DEBT	24,000
4,461	4,461	BAD DEBT	53,122
4,470	4,470	LOST ITEM	0
4,475	4,475	UNIFORM	(21)
4,486	4,486	SERVICE	30,240
4,490	4,490	MISC EXP	1,118
4,496	4,496	MISC. M.I.	7,772
4,510	4,510	REAL EST	0
4,600	4,600	LEASED E	18,702
5,110	5,110	MAINTEN/	78,177
5,120	5,120	MAINTEN/	7,726
5,130	5,130	ELECTRIC	87,400
5,131	5,131	NATURAL	27,773
5,133	5,133	WATER &	26,644
5,134	5,134	TRASH CC	7,794
5,140	5,140	PROP/PLA	8,108
5,160	5,160	GENERAL	38,198
5,165	5,165	MAINTEN/	13,763
5,210	5,210	DIETARY	181,781
5,220	5,220	DIETARY I	12,547
5,248	5,248	FOOD PUI	149,109
5,250	5,250	SUPPLIES	4,295
5,260	5,260	REPLACEI	1,533
5,270	5,270	KITCHEN	4,181
5,295	5,295	MEAL INC	(4,520)
5,310	5,310	LAUNDRY	45,248
5,340	5,340	LAUNDRY	2,358
5,370	5,370	REPLACEI	2,174
5,380			0
5,390	5,390	SUPPLIES	5,143
5,410	5,410	HOUSEKE	130,249
5,440	5,440	HOUSEKE	7,570
5,480	5,480	SUPPLIES	34,504
5,490	5,490	SUPPLIES	(300)
6,020	6,020	RN WAGE	228,197
6,030	6,030	DON WAG	62,849
6,035	6,035	ADON WA	0
6,040	6,040	RN PTO &	21,692
6,120	6,120	LPN WAGI	330,182
6,140	6,140	LPN PTO &	21,255
6,220	6,220	AIDES WA	571,130
6,240	6,240	AIDES PTC	31,874
6,245			
6,246			
6,247	6,247	AIDES CO	15,605
6,250			0
6,255			0
6,260			0
6,270	6,270	REHAB W/	75,016
6,275	6,275	REHAB PT	7,920
6,290	6,290	NURSING	16,280
6,295	6,295	NURSING	80,936
6,390	6,390	REPLACEI	4,965
6,490	6,490	OTHER	348
7,280	7,280	DRUG PUI	131,222
7,281	7,281	DRUG PUI	3,418
7,380	7,380	LABORAT	3,410
7,391	7,390	X-RAY SEI	2,429
7,393			6,145
7,510	7,510	ACTIVITIE	64,681
7,540	7,540	ACTIVITIE	5,010
7,590	7,590	ACTIVITIE	5,305
7,620	7,620	PHYSICAL	242,461
7,660	7,660	P.T. SUPP	122
7,710	7,710	SOCIAL SI	30,318
7,720	7,720	SOCIAL SI	2,858
7,730	7,730	SOCIAL SI	0
7,740	7,740	OCCUPAT	149,992
7,750			
7,770	7,770	SPEECH T	28,158
7,820	7,820	BEAUTICI/	0
7,890			0
7,960			0
8,120	8,120	INTEREST	214
8,125			0
8,130	8,130	DEPRECI/	190,301
8,150			0
9,510	9,510	INTEREST	(4)
9,520	9,520	MISC NON	0
9,530	4,220		0
	8,100		0
	9,702		0
	5,230		0
			291,459

Expenses Fixed Assets
0

Burnsides Community Health Center
2016 Cost Report
Supplemental Schedules

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

Line Item		
Purchased Drugs and Medications	$	134,640
Purchased Hospital Services		6,145
Purchased Laboratory Services		3,410
Purchased Radiology Services		2,429
Amount Reclassified to Line 39	$	146,624

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

Line Item		
Provider Participation Fee	$	52,155

3. Schedule V - Line 19 to Line 26 - Reclassifications

Line Item		
Professional Services - Line 19	$	(4,583)
Insurance - Prop Liab Malpractice - Line 26	$	4,583

Reclassifes premium payment erroneously
charged to professional fees account