

		FOR BHF USE				

LL1

**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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:** Burnside Nursing Home

**Address:** 410 North Second St, PO Box 219 Marshall 62441  
 Number City Zip Code

**County:** Clark

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

**HFS ID Number:** 37-0841315001

**Date of Initial License for Current Owners:** September 1963

**Type of Ownership:**

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> <u>501("c")(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Ben G. Lueken **Telephone Number:** (217) 465-8562

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/06 to 06/30/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Terry Weir</u>	
	(Title) <u>Board President</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Ben G. Lueken</u> <u>C.E.O.</u>	
	(Firm Name & Address) <u>Dimond Financial Consultants, Inc.</u> <u>208 E. Jasper Street, Paris, IL 61944</u>	
	(Telephone) <u>(217) 465-8562</u> Fax # <u>(217) 465-8563</u>	

**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 Burnside Nursing Home# 0007153 Report Period Beginning: 07/01/06 Ending: 06/30/07

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds 105

	1	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	<u>105</u>	Skilled (SNF)	<u>105</u>	<u>38,325</u>	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	<u>105</u>	TOTALS	<u>105</u>	<u>38,325</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,281</u>	<u>1,890</u>	<u>3,985</u>	<u>8,156</u>	8
9	SNF/PED					9
10	ICF	<u>10,443</u>	<u>10,777</u>	<u>375</u>	<u>21,595</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,724</u>	<u>12,667</u>	<u>4,360</u>	<u>29,751</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.63%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Meals on WheelsF. Does the facility maintain a daily midnight census? yes

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 09/01/1963

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 105 and days of care provided 365Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 06/30/07 Fiscal Year: 06/30/07

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

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/06 Ending: 06/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	299,006	22,047	9,773	330,826		330,826		330,826		1
2	Food Purchase		169,450		169,450		169,450	(21,951)	147,499		2
3	Housekeeping	99,310	21,430		120,740		120,740		120,740		3
4	Laundry	100,125	8,857	2,441	111,423		111,423		111,423		4
5	Heat and Other Utilities			159,614	159,614		159,614		159,614		5
6	Maintenance	110,166	4,593	59,972	174,731		174,731		174,731		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>608,607</b>	<b>226,377</b>	<b>231,800</b>	<b>1,066,784</b>		<b>1,066,784</b>	<b>(21,951)</b>	<b>1,044,833</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,752,783	288,293	42,168	2,083,244		2,083,244		2,083,244		10
10a	Therapy		545	294,558	295,103		295,103		295,103		10a
11	Activities	55,119	560	25,787	81,466		81,466		81,466		11
12	Social Services	59,703	134	3,506	63,343		63,343		63,343		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,867,605</b>	<b>289,532</b>	<b>366,019</b>	<b>2,523,156</b>		<b>2,523,156</b>		<b>2,523,156</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	58,090			58,090		58,090		58,090		17
18	Directors Fees										18
19	Professional Services			46,615	46,615		46,615		46,615		19
20	Dues, Fees, Subscriptions & Promotions			17,144	17,144		17,144	(10,685)	6,459		20
21	Clerical & General Office Expenses	133,932	14,866	45,857	194,655		194,655		194,655		21
22	Employee Benefits & Payroll Taxes			423,709	423,709		423,709	(204)	423,505		22
23	Inservice Training & Education			545	545		545		545		23
24	Travel and Seminar			4,248	4,248		4,248		4,248		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			77,946	77,946		77,946		77,946		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>192,022</b>	<b>14,866</b>	<b>616,064</b>	<b>822,952</b>		<b>822,952</b>	<b>(10,889)</b>	<b>812,063</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,668,234</b>	<b>530,775</b>	<b>1,213,883</b>	<b>4,412,892</b>		<b>4,412,892</b>	<b>(32,840)</b>	<b>4,380,052</b>		<b>29</b>

\*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 Burnside Nursing Home #0007153 Report Period Beginning: 07/01/06 Ending: 06/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			110,669	110,669		110,669	(18,431)	92,238			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			110,669	110,669		110,669	(18,431)	92,238			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,488	57,488		57,488		57,488			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			57,488	57,488		57,488		57,488			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,668,234	530,775	1,382,040	4,581,049		4,581,049	(51,271)	4,529,778			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 Burnside Nursing Home

# 0007153

Report Period Beginning:

07/01/06

Ending:

06/30/07

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,951)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(490)	20		28
29	Other-Attach Schedule	(28,830)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (51,271)</b>		<b>\$</b>	<b>30</b>

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	2	
		Amount	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (51,271)</b>		<b>37</b>

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

BHF USE ONLY						
48		49		50		51
						52

Burnside Nursing Home

ID# 0007153

Report Period Beginning: 07/01/06

Ending: 06/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non Care Depreciation	\$ (18,431)	30	1
2	Employment Recognition	(204)	22	2
3	Patient Subscriptions	(296)	20	3
4	Other Advertising	(9,899)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(28,830)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Burnside Nursing Home

# 0007153

Report Period Beginning:

07/01/06

Ending:

06/30/07

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(21,951)	0	0	0	0	0	0	0	0	0	0	(21,951)	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	<b>TOTAL General Services</b>	<b>(21,951)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(21,951)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(10,685)	0	0	0	0	0	0	0	0	0	0	(10,685)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(204)	0	0	0	0	0	0	0	0	0	0	(204)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(10,889)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(10,889)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(32,840)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(32,840)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Burnside Nursing Home

# 0007153

Report Period Beginning:

07/01/06 Ending:

Summary B

06/30/07

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(18,431)	0	0	0	0	0	0	0	0	0	0	(18,431)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(18,431)</b>	<b>0</b>	<b>(18,431)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(51,271)</b>	<b>0</b>	<b>(51,271)</b>	<b>45</b>									

Facility Name & ID Number Burnside Nursing Home

# 0007153

Report Period Beginning:

07/01/06

Ending:

06/30/07

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Non-Applicable				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$	Non-Applicable		\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/06 Ending: 06/30/07

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Non-Applicable								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Burnside Nursing Home

# 0007153

Report Period Beginning: 07/01/06

Ending: 06/30/07

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1				Non-Applicable			\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Burnside Nursing Home 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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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 Burnside Nursing Home

# 0007153 Report Period Beginning:

07/01/06 Ending:

06/30/07

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Robert Flowers Village - Independent Living Facility - 8 Units

Burnhaven Apartments - Independent Living Facility - 8 Units

Cork Medical Center - Provides Outpatient Medical Care - Lease to Unrelated Party

All the above facilities have their own accounting records and share no common costs with Burnside's Community Health Center

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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		226,425	1963	\$ 22,963	1
2		8,400	1982	12,376	2
3	TOTALS	234,825		\$ 35,339	3

Facility Name & ID Number **Burnside Nursing Home**# **0007153**

Report Period Beginning:

**07/01/06**

Ending:

**06/30/07****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1963	1963	\$ 823,909	\$ 3,323	15,30	\$ 3,323		\$ 808,320	4
5			1995	1995	1,100,822	27,521	30	27,521		327,733	5
6			1997	1997	737,255	18,431	20	18,431		179,726	6
7			1997	1997	(737,255)	(18,431)	20,30	(18,431)		(179,726)	7
8			2002	2002	3,982	199	20	199		935	8
	<b>Improvement Type**</b>										
9		Elevator		1965	8,581		20			8,581	9
10		Safety Doors and Improvements		1972	9,375		10			9,375	10
11		Improvements		1974	4,562		10			4,562	11
12		Sprinkler System		1975	39,041		20			39,041	12
13		Improvements		1977	2,892		10			2,892	13
14		Improvements		1978	636		10			636	14
15		Improvements		1979	11,842					11,842	15
16		Awning, Dining Room Windows		1981	21,654		10,30			21,654	16
17		Drapes, Guttering Drainage Work		1982	13,093					13,093	17
18		Drapes		1983	5,526		15			5,526	18
19		Drapes, Lighting & Kitchen Cabinet Doors		1984	7,163		10,15			7,164	19
20		Fire System, Kitchen Drapes, Steel Wall Kitchen		1985	25,083		5,25			25,083	20
21		Sprinklers, Carpet, Drapes		1987	9,272	152	5,25	152		9,272	21
22		Building Improvements, Water Pump, Sewer		1988	9,350	449	8,20	449		9,256	22
23		Smoke Detector, Remodeling, Air Conditioner		1989	31,888	1,449	5,20	1,449		28,361	23
24		Door Alarm, Fire Alarms, Remodeling		1990	13,402	355	10,20	355		12,373	24
25		Remodeling		1991	5,798	120	10,20	120		5,342	25
26		Office Remodeling Door		1993	8,177		10,20			9,774	26
27		Water System, Window		1994	5,079	352	10,20	352		4,584	27
28		New Wing Addition		1995	88,453	5,224	10,20	5,224		61,879	28
29		Wallpaper, Blinds, Phone System		1996	4,335	217	20	217		2,425	29
30		Ceiling Work, Insulation		1997	24,991	1,249	20	1,249		12,234	30
31		Backflow System/Sprinkler System		1998	2,990	150	20	150		1,361	31
32		Roofing, Remodeling		1999	41,517	2,124	10,20	2,124		18,042	32
33		Draperies, Main Dining Room		2000	2,735	273	10	273		1,912	33
34		Windows, Dining		2000	3,620	241	15	241		1,668	34
35		Sprinkler Head		2001	560	37	15	37		207	35
36		Lights, Call System, Remodeling, Drapes, Roof		1986	67,975		5,25			67,975	36

\*Total beds on this schedule must agree with page 2.

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

**See Page 12A, Line 70 for total**

Facility Name &amp; ID Number Burnside Nursing Home

# 0007153

Report Period Beginning:

07/01/06

Ending:

06/30/07

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Parking Lot	1973	\$ 19,280	\$	10	\$	\$	\$ 19,280	37
38	Landscaping	1974	2,891		10			2,891	38
39	Parking Lot Improvement	1975	3,989		10			3,989	39
40	Blacktop Sealing, Culvert Installation	1980	13,853		10			13,853	40
41	Blacktop at Shed, Sewer	1981	5,170		15			5,170	41
42	Landscaping, Grading, Parking Lot Improvement	1982	15,497		5,15			15,497	42
43	Asphalt Sealing	1983	3,511		5			3,511	43
44	Landscaping, Road Improvement	1984	4,350		5,10			4,350	44
45	Landscaping at Chapel	1988	675		10			675	45
46	Landscaping	1989	220		10			220	46
47	Road Resurfacing	1990	9,188		5,15			9,188	47
48	Rock	1992	330		10			330	48
49	Asphalt Sealing	1993	20,570		5			20,570	49
50	Landscaping, Fire Hydrant	1995	4,807	294	10,20	294		3,572	50
51	Parking Lot Paving	1999	11,850	1,185	10	1,185		10,665	51
52	Landscaping	2000	500	33	19	33		257	52
53	Chapel	1985	229,191	7,284	10,30	7,284		171,530	53
54	Draperies and Carpet	1986	4,252		20			4,252	54
55	Roof - New Shingles	2002	3,819	255	15	255		1,296	55
56	Roof on Garage	2000	791	53	15	53		358	56
57	Building Improvements, Generator, Transformer	2005	82,983	5,532	15	5,532		13,830	57
58	Building Improvements, Bed Panels, Mattress	2006	98,898	4,233	10,20	4,233		4,233	58
59									59
60									60
61	IDPA Desk Review Reclassification		18,478					18,478	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,953,396	\$ 62,304		\$ 62,304	\$	\$ 1,861,097	70

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

Facility Name & ID Number **Burnside Nursing Home**

# **0007153**

Report Period Beginning:

**07/01/06**

Ending:

**06/30/07**

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ <b>2,953,396</b>	\$ <b>62,304</b>		\$ <b>62,304</b>	\$	\$ <b>1,861,097</b>	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
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>2,953,396</b>	\$ <b>62,304</b>		\$ <b>62,304</b>	\$	\$ <b>1,861,097</b>	34

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

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/06 Ending: 06/30/07

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 508,328	\$ 27,175	\$ 27,175	\$	10	\$ 356,784	71
72	Current Year Purchases	95,561	2,759	2,759		10	2,759	72
73	Fully Depreciated Assets	159,795				10	159,795	73
74	IDPA Reclass Desk Review	(18,478)					(18,478)	74
75	TOTALS	\$ 745,206	\$ 29,934	\$ 29,934	\$		\$ 500,860	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Local Transportation	1981 GMC Rally Van	1981	\$ 13,873	\$	\$	\$	5	\$ 13,873	76
77	Local Transportation	1987 Dodge Pick Up	1987	8,212				5	8,212	77
78										78
79										79
80	TOTALS			\$ 22,085	\$	\$	\$		\$ 22,085	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)	\$ 3,756,026	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 92,238	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 92,238	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,384,042	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 Burnside Nursing Home

# 0007153

Report Period Beginning: 07/01/06

Ending: 06/30/07

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ _____			7

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \_\_\_\_\_ \*

**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			\$ <u>N/A</u>	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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)	
<b>TOTAL TRAINED</b>	

- (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 Burnside Nursing Home# 0007153

Report Period Beginning:

07/01/06

Ending:

06/30/07

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs			N/A				#VALUE!
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	#VALUE!

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 Burnside Nursing Home# 0007153Report Period Beginning: 07/01/06

Ending:

06/30/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 115,011	\$	1
2	Cash-Patient Deposits	5,276		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	615,195		3
4	Supply Inventory (priced at <u>Cost</u> )	39,152		4
5	Short-Term Investments	2,297,266		5
6	Prepaid Insurance	14,519		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,086,419	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,339		13
14	Buildings, at Historical Cost	2,665,968		14
15	Leasehold Improvements, at Historical Cost	1,045,198		15
16	Equipment, at Historical Cost	785,768		16
17	Accumulated Depreciation (book methods)	(2,567,553)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,964,720	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,051,139	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 71,399	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,377		30
31	Accrued Taxes Payable (excluding real estate taxes)	64,149		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Trust Account</u>	5,276		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 355,201	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due to Robert Flowers Village</u>	290,166		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 290,166	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 645,367	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,405,772	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,051,139	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,461,879</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>4,461,879</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(65,107)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (65,107)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Interdivisional Transfer</b>	9,000	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 9,000	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 4,405,772	<b>24</b> *

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

Facility Name & ID Number Burnside Nursing Home# 0007153Report Period Beginning: 07/01/06Ending: 06/30/07**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,015,867	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,015,867	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	572,570	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 572,570	8
<b>C. Other Operating Revenue</b>			
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	21,951	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	280,105	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,301	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 312,357	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	442,658	24
25	Interest and Other Investment Income***	116,538	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 559,196	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending Revenue</b>	1,003	28
28a	<b>Misc. Income - Royalties, Refund &amp; Rebates</b>	54,949	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 55,952	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,515,942	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,066,784	31
32	Health Care	2,523,156	32
33	General Administration	822,952	33
<b>B. Capital Expense</b>			
34	Ownership	110,669	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	57,488	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,581,049	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(65,107)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (65,107)	43

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

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

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

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

Facility Name & ID Number Burnside Nursing Home

# 0007153

Report Period Beginning: 07/01/06

Ending: 06/30/07

**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	2,040	2,080	\$ 69,214	\$ 33.28	1
2	Assistant Director of Nursing	4,160	4,160	72,818	17.50	2
3	Registered Nurses	5,728	6,132	134,348	21.91	3
4	Licensed Practical Nurses	36,043	39,263	647,036	16.48	4
5	CNAs & Orderlies	67,676	72,817	738,308	10.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,973	7,645	91,059	11.91	8
9	Activity Director	1,246	1,398	16,562	11.85	9
10	Activity Assistants	4,995	5,203	38,557	7.41	10
11	Social Service Workers	3,816	4,208	59,703	14.19	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	39,879	19.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,794	28,058	259,127	9.24	15
16	Dishwashers					16
17	Maintenance Workers	7,950	8,390	110,166	13.13	17
18	Housekeepers	10,709	11,703	99,310	8.49	18
19	Laundry	9,168	9,971	100,125	10.04	19
20	Administrator	1,800	2,000	58,090	29.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,080	38,228	18.38	23
24	Clerical	7,963	8,411	95,704	11.38	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	<b>TOTAL (lines 1 - 33)</b>	<b>200,141</b>	<b>215,599</b>	<b>\$ 2,668,234 *</b>	<b>\$ 12.38</b>	<b>34</b>

\* 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	143	\$ 6,600	1-3	35
36	Medical Director				36
37	Medical Records Consultant	13	619	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	100 mo	1,200	10-3	39
40	Physical Therapy Consultant	2,698	137,593	109-3	40
41	Occupational Therapy Consultant	2,178	111,082	109-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	900	45,883	109-3	43
44	Activity Consultant	48	2,640	11-3	44
45	Social Service Consultant	48	2,640	12-3	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>6,028</b>	<b>\$ 308,257</b>		<b>49</b>

**C. CONTRACT NURSES**

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

Facility Name & ID Number Burnside Nursing Home

# 0007153

Report Period Beginning: 07/01/06

Ending: 06/30/07

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Carla Honselman	Former Administrator	0	\$ 32,830	Workers' Compensation Insurance	\$ 73,699	IDPH License Fee	\$	
Sean Medsker	Administrator	0	25,260	Unemployment Compensation Insurance	44,650	Advertising: Employee Recruitment		
				FICA Taxes	239,754	Health Care Worker Background Check		
				Employee Health Insurance	57,000	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	6,459	
				Employee Education Reimb. & Recog.	8,402			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 58,090					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	4,248
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Entertainment Expense	( )
(Attach a copy of any management service agreement)							(agree to Sch. V,	
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount				(agree to Sch. V,	
Daughetee & Parks, P.C.	Accounting		\$ 7,500				line 24, col. 8)	
Dimond Financial Consltns, Inc.	Accounting		29,115				\$ 4,248	
MPIC	Legal		10,000					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 46,615					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Burnside Nursing Home

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA 5796
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,398 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 57,488  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? None If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Daughhete & Parks, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.