

		FOR BHF USE					

LL1

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0007153</u></p> <p>Facility Name: <u>Burnsides Community Health Ctr</u></p> <p>Address: <u>410 North Second St, PO Box 219</u> <u>Marshall</u> <u>62441</u> Number City Zip Code</p> <p>County: <u>Clark</u></p> <p>Telephone Number: <u>(217) 826-2358</u> Fax # <u>(217) 826-2367</u></p> <p>HFS ID Number: <u>37-0841315001</u></p> <p>Date of Initial License for Current Owners: <u>September 1963</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501("c")(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Bernard G. Lueken</u> Telephone Number: <u>(217) 465-8562</u> Email Address: _____</p>	<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	IRS Exemption Code <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	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/08</u> to <u>06/30/09</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Terry Weir</u></td> </tr> <tr> <td>(Title) <u>Board President</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Bernard G. Lueken</u> <u>C. E. O.</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Dimond Financial Consultants, Inc.</u> <u>208 E. Jasper Street, Paris, IL 61944</u></td> </tr> <tr> <td>(Telephone) <u>(217) 465-8562</u> Fax # <u>(217) 465-8563</u></td> </tr> <tr> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Terry Weir</u>	(Title) <u>Board President</u>	Paid Preparer	(Signed) _____	(Print Name and Title) <u>Bernard 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
<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																																	
IRS Exemption Code <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	_____																																	
Officer or Administrator of Provider	(Signed) _____																																		
	(Type or Print Name) <u>Terry Weir</u>																																		
	(Title) <u>Board President</u>																																		
Paid Preparer	(Signed) _____																																		
	(Print Name and Title) <u>Bernard 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 Burnsides Community Health Ctr

0007153 Report Period Beginning: 07/01/08 Ending: 06/30/09

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 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>1,604</u>	<u>2,093</u>	<u>4,067</u>	<u>7,764</u>	8	
9	SNF/PED					9	
10	ICF	<u>12,757</u>	<u>12,270</u>	<u>145</u>	<u>25,172</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>14,361</u>	<u>14,363</u>	<u>4,212</u>	<u>32,936</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.94%

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 Wheels

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

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

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 365

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 06/30/2009 Fiscal Year: 06/30/2009

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

Facility Name & ID Number Burnsides Community Health Ctr # 0007153 Report Period Beginning: 07/01/08 Ending: 06/30/09

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
	A. General Services										
1	Dietary	321,102	22,089	12,215	355,406		355,406		355,406		1
2	Food Purchase		192,936		192,936		192,936	(9,202)	183,734		2
3	Housekeeping	108,491	33,960		142,451		142,451		142,451		3
4	Laundry	116,977	21,512	2,066	140,555		140,555		140,555		4
5	Heat and Other Utilities			169,835	169,835		169,835		169,835		5
6	Maintenance	101,695	8,072	83,176	192,943		192,943		192,943		6
7	Other (specify):*										7
8	TOTAL General Services	648,265	278,569	267,292	1,194,126		1,194,126	(9,202)	1,184,924		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,020,337	328,145	95,779	2,444,261		2,444,261		2,444,261		10
10a	Therapy		247	273,897	274,144		274,144		274,144		10a
11	Activities	107,155	3,213	11,072	121,440		121,440		121,440		11
12	Social Services	69,063		2,420	71,483		71,483		71,483		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,196,555	331,605	389,168	2,917,328		2,917,328		2,917,328		16
	C. General Administration										
17	Administrative	62,894			62,894		62,894		62,894		17
18	Directors Fees										18
19	Professional Services			40,782	40,782		40,782		40,782		19
20	Dues, Fees, Subscriptions & Promotions			22,559	22,559		22,559	(14,813)	7,746		20
21	Clerical & General Office Expenses	160,827	26,261	52,559	239,647		239,647		239,647		21
22	Employee Benefits & Payroll Taxes			473,444	473,444		473,444	(3,335)	470,109		22
23	Inservice Training & Education			2,101	2,101		2,101		2,101		23
24	Travel and Seminar			3,523	3,523		3,523		3,523		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			74,094	74,094		74,094		74,094		26
27	Other (specify):*										27
28	TOTAL General Administration	223,721	26,261	669,062	919,044		919,044	(18,148)	900,896		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,068,541	636,435	1,325,522	5,030,498		5,030,498	(27,350)	5,003,148		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			149,202	149,202		149,202	(18,431)	130,771			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	TOTAL Ownership			149,202	149,202		149,202	(18,431)	130,771			37
	Ancillary Expense											
	E. Special Cost Centers											
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			60,137	60,137		60,137		60,137			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			60,137	60,137		60,137		60,137			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,068,541	636,435	1,534,861	5,239,837		5,239,837	(45,781)	5,194,056			45

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

Burnsides Community Health Ctr

ID# 0007153

Report Period Beginning: 07/01/08

Ending: 06/30/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Non-Care Depreciation	\$ (18,431)	30	1
2	Employment Recognition	(3,335)	22	2
3	Patient Subscriptions	(296)	20	3
4	Other Advertising	(14,027)	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	Total	(36,089)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burnsides Community Health Ctr# 0007153

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,202)	0	0	0	0	0	0	0	0	0	0	(9,202)	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	(9,202)	0	(9,202)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(14,813)	0	0	0	0	0	0	0	0	0	0	(14,813)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(3,335)	0	0	0	0	0	0	0	0	0	0	(3,335)	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	TOTAL General Administration	(18,148)	0	(18,148)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,350)	0	(27,350)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burnsides Community Health Ctr# 0007153

Report Period Beginning:

07/01/08 Ending:06/30/09

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

	Capital Expense	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)	
	D. Ownership													
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	TOTAL Ownership	(18,431)	0	0	0	0	0	0	0	0	0	0	(18,431)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(45,781)	0	0	0	0	0	0	0	0	0	0	(45,781)	45

Facility Name & ID Number

Burnsides Community Health Ctr

0007153

Report Period Beginning:

07/01/08

Ending:

06/30/09

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		\$			\$	\$	1
2	V			Non-Applicable				2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Burnsides Community Health Ctr # 0007153 Report Period Beginning: 07/01/08 Ending: 06/30/09

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 Burnsides Community Health Ctr

0007153

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

Facility Name & ID Number

Burnsides Community Health Ctr

0007153

Report Period Beginning:

07/01/08

Ending:

06/30/09

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					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		Related**	YES											NO	Original			
	A. Directly Facility Related																	
	Long-Term																	
1				Non-Applicable			\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$			\$	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$	\$			\$	15						

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

* 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 Health Ctr

0007153

Report Period Beginning:

07/01/08

Ending:

06/30/09

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 of the above facilities have their own accounting records and share no common costs with Burnsides Community Health Center.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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:

	1	2	3	4	
A. Land.	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 Burnsides Community Health Ctr# 0007153

Report Period Beginning:

07/01/08

Ending:

06/30/09**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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1963	1963	\$ 823,909	\$ 3,323	15,30	\$ 3,323	\$	\$ 814,966	4
5			1995	1995	1,100,822	27,521	30	27,521		382,775	5
6			1997	1997	737,255	18,431	20	18,431		216,588	6
7			1997	1997	(737,255)	(18,431)	20,30	(18,431)		(216,588)	7
8			2002	2002	3,982	199	20	199		1,333	8
	Improvement Type**										
9		Elevator		1965	8,581		20			8,581	9
10		Safety Doors and Improvements		1972	9,375		10			9,375	10
11		Improvements		1974	4,562		10			4,562	11
12		Sprinkler System		1975	39,041		20			39,041	12
13		Improvements		1977	2,892		10			2,892	13
14		Improvements		1978	636		10			636	14
15		Improvements		1979	11,842					11,842	15
16		Awning, Dining Room Windows		1981	21,654		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		5,25			9,272	21
22		Building Improvements, Water Pump, Sewer		1988	9,350		8,20			9,350	22
23		Smoke Detector, Remodeling, Air Conditioner		1989	31,888	1,449	5,20	1,449		31,259	23
24		Door Alarm, Fire Alarms, Remodeling		1990	13,402	355	10,20	355		13,083	24
25		Remodeling		1991	5,798	120	10,20	120		5,582	25
26		Office Remodeling Door		1993	8,177		10,20			9,774	26
27		Water System, Windows		1994	5,079	143	10,20	143		5,079	27
28		New Wing Additions		1995	88,453	5,224	10,20	5,224		72,327	28
29		Wallpaper, Blinds, Phone System		1996	4,335	217	20	217		2,859	29
30		Ceiling Work, Insulation		1997	24,991	1,249	20	1,249		14,732	30
31		Backflow System/Sprinkler System		1998	2,990	150	20	150		1,661	31
32		Roofing, Remodeling		1999	41,517	2,124	10,20	2,124		22,290	32
33		Draperies, Main Dining Room		2000	2,735	273	10	273		2,458	33
34		Windows, Dining		2000	3,620	241	15	241		2,150	34
35		Sprinkler Heads		2001	560	37	15	37		281	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 & ID Number Burnsides Community Health Ctr# 0007153

Report Period Beginning:

07/01/08

Ending:

06/30/09**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	<u>Parking Lot</u>	1973	\$ 19,280	\$	10	\$	\$	\$ 19,280	37
38	<u>Landscaping</u>	1974	2,891		10			2,891	38
39	<u>Parking Lot Improvements</u>	1975	3,989		10			3,989	39
40	<u>Blacktop Sealing, Culvert Installation</u>	1980	13,853		10			13,853	40
41	<u>Blacktop at Shed, Sewer</u>	1981	5,170		15			5,170	41
42	<u>Landscaping, Grading, Parking Lot Improvements</u>	1982	15,497		5,15			15,497	42
43	<u>Asphalt Sealing</u>	1983	3,511		5			3,511	43
44	<u>Landscaping, Road Improvement</u>	1984	4,350		5,10			4,350	44
45	<u>Landscaping at Chapel</u>	1988	675		10			675	45
46	<u>Landscaping</u>	1989	220		10			220	46
47	<u>Road Resurfacing</u>	1990	9,188		5,15			9,188	47
48	<u>Rock</u>	1992	330		10			330	48
49	<u>Asphalt Sealing</u>	1993	20,570		5			20,570	49
50	<u>Landscaping, Fire Hydrants</u>	1995	4,807	294	10,20	294		4,160	50
51	<u>Parking Lot Paving</u>	1999	11,850		10			11,850	51
52	<u>Landscaping</u>	2000	500	33	19	33		323	52
53	<u>Chapel</u>	1985	229,191	7,284	10,30	7,284		186,098	53
54	<u>Draperies and Carpet</u>	1986	4,252		20			4,252	54
55	<u>Roof -- New Shingles</u>	2002	3,819	255	15	255		1,806	55
56	<u>Roof on Garage</u>	2000	791	53	15	53		464	56
57	<u>Generator, Generator Pad</u>	2005	65,163	3,258	15	3,258		14,933	57
58	<u>Transformer, Blinds, Wallpaper</u>	2005	10,802	663	15	663		2,904	58
59	<u>Paint</u>	2005	7,018	1,572	15	1,572		7,018	59
60	<u>Paint, Carpet</u>	2006	4,455	297	10,20	297		1,283	60
61	<u>Air Conditioner, Furnace, Windows, Doors</u>	2006	12,121	985	10,20	985		2,685	61
62	<u>Compressor, Lighting</u>	2006	4,533	927	10,20	927		2,781	62
63	<u>Disposal Unit, Architectual Service</u>	2006	13,451	1,902	10,20	1,902		5,706	63
64	<u>Water Heater, Resin Bed Tank, Plumbing, Sprinkler System</u>	2007	33,058	2,203	10,20	2,203		3,763	64
65	<u>Boiler, Furnace, Air Conditioner, Windows</u>	2007	206,728	16,743	10,20	16,743		26,076	65
66	<u>Electrical Installation, Drapes, Transmitter</u>	2007	38,918	2,595	10,20	2,595		4,546	66
67	<u>Conference Room Addition, Carpet, Paint</u>	2007	107,533	7,169	10,20	7,169		9,841	67
68	<u>Conference Room Addition</u>	2008	129,172	4,024	10,20	4,024		4,024	68
69	<u>IDPA Desk Review</u>	2008	18,478					18,478	69
70	TOTAL (lines 4 thru 69)		\$ 3,404,467	\$ 92,882		\$ 92,882	\$	\$ 2,031,170	70

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

Facility Name & ID Number **Burnsides Community Health Ctr**

0007153

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	Totals from Page 12A, Carried Forward		\$ 3,404,467	\$ 92,882		\$ 92,882	\$	\$ 2,031,170	1
2	Asphalt	2008	1,500	83	15	83		83	2
3	Boiler	2008	43,995	1,100	20	1,100		1,100	3
4	Awning	2008	7,000	350	10	350		350	4
5	Compressor	2008	6,532	279	10	279		279	5
6	Sprinkler System	2008	8,539	356	20	356		356	6
7	Elevator	2008	4,833	322	10	322		322	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	TOTAL (lines 1 thru 33)		\$ 3,476,866	\$ 95,372		\$ 95,372	\$	\$ 2,033,660	34

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

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	\$ 702,052	\$ 32,407	\$ 32,407	\$	10	\$ 423,471	71
72	Current Year Purchases	47,423	2,900	2,900		10	2,900	72
73	Fully Depreciated Assets	159,795				10	159,795	73
74	IDPA Reclass Desk Review	(18,478)					(18,478)	74
75	TOTALS	\$ 890,792	\$ 35,307	\$ 35,307	\$		\$ 567,688	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	1987 Dodge Pickup	1987	\$ 8,212	\$	\$	\$	5	\$ 8,212	76
77	Local Transportation	2004 Ford Econoline	2009	1,847	92	92		5	92	77
78										78
79										79
80	TOTALS			\$ 10,059	\$ 92	\$ 92	\$		\$ 8,304	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,413,056	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 130,771	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 130,771	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)	\$ 2,609,652	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.

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:				\$ _____			3
4	Additions				N/A			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: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			N/A		18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	#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 Burnsides Community Health Ctr

0007153

Report Period Beginning: 07/01/08

Ending: 06/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/09 (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	\$ 267,091	\$	1
2	Cash-Patient Deposits	10,012		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	790,883		3
4	Supply Inventory (priced at <u>Cost</u>)	37,482		4
5	Short-Term Investments	1,286,731		5
6	Prepaid Insurance	28,032		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,420,231	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,339		13
14	Buildings, at Historical Cost	2,672,410		14
15	Leasehold Improvements, at Historical Cost	1,580,703		15
16	Equipment, at Historical Cost	900,851		16
17	Accumulated Depreciation (book methods)	(2,830,025)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,359,278	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,779,509	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 52,791	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	249,035		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,306		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	<u>Trust Account</u>	10,012		36
37	<u>Deferred Revenue</u>	56,146		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 407,290	\$	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)	\$ 407,290	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,372,219	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,779,509	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,569,169	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,569,169	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(145,950)	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)	\$ (145,950)	17
	B. Transfers (Itemize):		
18	Interdivisional Transfer	(51,000)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (51,000)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,372,219	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Burnsides Community Health Ctr**# **0007153**Report Period Beginning: **07/01/08**Ending: **06/30/09**

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,170,732	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,170,732	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	521,276	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 521,276	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	9,202	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	257,561	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,822	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 280,585	23
D. Non-Operating Revenue			
24	Contributions	1,251	24
25	Interest and Other Investment Income***	56,526	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 57,777	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Revenue	452	28
28a	Miscellaneous Income - Refund, Rebate, & Royalties	63,065	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 63,517	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,093,887	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,194,126	31
32	Health Care	2,917,328	32
33	General Administration	919,044	33
B. Capital Expense			
34	Ownership	149,202	34
C. Ancillary Expense			
35	Special Cost Centers	60,137	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,239,837	40
41	Income before Income Taxes (line 30 minus line 40)**	(145,950)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (145,950)	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 **Burnsides Community Health Ctr**

0007153

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	2,000	2,080	\$ 64,980	\$ 31.24	1
2	Assistant Director of Nursing	2,040	2,080	48,513	23.32	2
3	Registered Nurses	8,050	8,825	192,906	21.86	3
4	Licensed Practical Nurses	40,340	42,160	756,441	17.94	4
5	CNAs & Orderlies	76,932	82,647	835,352	10.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,735	10,748	122,144	11.36	8
9	Activity Director	1,985	2,149	28,107	13.08	9
10	Activity Assistants	7,381	7,947	79,049	9.95	10
11	Social Service Workers	3,910	4,567	69,063	15.12	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	38,214	18.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,473	29,928	282,888	9.45	15
16	Dishwashers					16
17	Maintenance Workers	6,155	6,570	101,695	15.48	17
18	Housekeepers	11,018	12,018	108,491	9.03	18
19	Laundry	10,446	11,586	116,977	10.10	19
20	Administrator	2,000	2,080	62,894	30.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,080	40,558	19.50	23
24	Clerical	8,571	9,215	120,269	13.05	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)	222,036	238,760	\$ 3,068,541 *	\$ 12.85	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	527	\$ 8,436	1-3	35
36	Medical Director	500 mo.	6,000	9	36
37	Medical Records Consultant	19	880	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	234 mo.	2,802	10-3	39
40	Physical Therapy Consultant	2,550	130,059	10a-3	40
41	Occupational Therapy Consultant	1,985	101,246	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	835	42,592	10a-3	43
44	Activity Consultant	44	2,420	11-3	44
45	Social Service Consultant	44	2,420	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	6,004	\$ 296,855		49

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	TOTAL (lines 50 - 52)		\$		53

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	
Sean Medsker	Administrator		\$ 62,894	Workers' Compensation Insurance	\$ 98,399	IDPH License Fee	\$	
				Unemployment Compensation Insurance	30,985	Advertising: Employee Recruitment		
				FICA Taxes	270,090	Health Care Worker Background Check		
				Employee Health Insurance	65,953	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	7,746	
				Employee Education, Reimb. & Recognition	4,682			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,894					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 470,109	Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Polsinelli, Shalton, & Flanigan	Legal		\$ 2,990			\$	Out-of-State Travel	\$
Daughhetee & Parks, P.C.	Accounting		9,750					
Dimond Financial Consultants	Accounting		28,042				In-State Travel	
							Seminar Expense	3,523
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 40,782	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 3,523

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Burnsides Community Health Ctr# 0007153Report Period Beginning: 07/01/08Ending: 06/30/09**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. \$ 46,315 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. \$ 60,137
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: DBH & Associates, LLC
- (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.