

		FOR BHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0007153 Facility Name: Burnsidess Community Hlth Ctr Address: 410 N 2nd St Box 219 Marshall 62441 County: Clark Telephone Number: 217 826-2358 Fax # () HFS ID Number: Date of Initial License for Current Owners: 1963 Type of Ownership: ☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501 C 3 ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

In the event there are further questions about this report, please contact:

Name: David Underwood

Telephone Number: 309823-7135

Email Address:

Facility Name & ID Number Burnsides Community Hlth Ctr

0007153 Report Period Beginning: 07/01/15 Ending: 06/30/16

III. STATISTICAL DATA

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

	1	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	95	Skilled (SNF)	95	34,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	95	TOTALS	95	34,770	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,618	10,932	2,431	22,981	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,618	10,932	2,431	22,981	14

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

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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 9-1-63

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 95 and days of care provided 2,431

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: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

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

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

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

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

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

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			190,301	190,301		190,301		190,301			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			214	214		214	(4)	210			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,210	17,210		17,210		17,210			35
36	Other (specify):*											36
37	TOTAL Ownership			207,725	207,725		207,725	(4)	207,721			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					146,624	146,624		146,624			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					52,155	52,155		52,155			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					198,779	198,779		198,779			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,195,342	509,047	1,739,515	4,443,904		4,443,904	(49,672)	4,394,232			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,982)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)			24
25	Fund Raising, Advertising and Promotional	(17,686)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (49,672)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

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

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(7,982)	19	22
23				23
24		(24,000)	27	24
25		(17,686)	20	25
26				26
27		0	22	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(49,668)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,982)	0	0	0	0	0	0	0	0	0	0	(7,982)	19
20	Fees, Subscriptions & Promotions	(17,686)	0	0	0	0	0	0	0	0	0	0	(17,686)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	27
28	TOTAL General Administration	(49,668)	0	0	0	0	0	0	0	0	0	0	(49,668)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(49,668)	0	0	0	0	0	0	0	0	0	0	(49,668)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4)	0	0	0	0	0	0	0	0	0	0	(4)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4)	0	0	0	0	0	0	0	0	0	0	(4)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(49,672)	0	0	0	0	0	0	0	0	0	0	(49,672)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Board of Directors List Attached (Community Board - no individual ownership exists)						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

	1 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	No compensation is paid								\$		1
2	to any Board Member										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1							\$					\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	First Bank			Line of Credit								214	6	
7													7	
8													8	
9	TOTAL Facility Related						\$					\$	214	9
	B. Non-Facility Related*													
10	Interest Income											(4)	10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	(4)	14
15	TOTALS (line 9+line14)							\$				\$	210	15

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

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

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

FACILITY NAME Burnsides Community Hlth Ctr COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0007153

CONTACT PERSON REGARDING THIS REPORT David M Underwood

TELEPHONE 309-823-7135 FAX #: ()

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	46,819	B. General Construction Type:	Exterior Limestone	Frame Wood	Number of Stories	1
------------------------	---------------	--------------------------------------	---------------------------	-------------------	--------------------------	----------

C. Does the Operating Entity? ☒ (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

This facility has its own accounting records and shares no common costs with Burnside 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	Nursing Facility	226,425	1963	\$ 22,963	1
2	Nursing Facility	8,400	1982	12,376	2
3	TOTALS	234,825		\$ 35,339	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	95		1963	1963	\$ 823,909	\$		\$		4
5			1995	1995	1,100,822					5
6			2002	2002	3,982					6
7										7
8										8
	Improvement Type**									
9	Elevator		1965		8,581					9
10	Safety Doors		1972		9,375					10
11	Improvements		1974		4,562					11
12	Sprinkler System		1975		39,041					12
13	Improvements		1977		2,892					13
14	Improvements		1978		636					14
15	Improvements		1979		11,842					15
16	Awning, Dining Room Windows		1981		21,654					16
17	Drapes, Guttering & Drainage		1982		13,093					17
18	Drapes		1983		5,526					18
19	Drapes, Lighting & Kitchen Cabinet Doors		1984		7,163					19
20	Fire System		1985		25,083					20
21	Sprinklers, Carpet, Drapes		1987		9,272					21
22	Bldg Improvements, Water Pump, Sewer		1988		9,350					22
23	Smoke Detector, AC		1989		31,888					23
24	Door and Fire Alarms		1990		13,402					24
25	Remodeling		1991		5,798					25
26	Office Remodel		1993		8,177					26
27	Water Systems, Windows		1994		5,079					27
28	New Wing Additions		1995		88,453					28
29	Wallpaper, Blinds & Phone System		1996		4,335					29
30	Ceiling Work, Insulation		1997		24,991					30
31	Backflow System & Sprinklers		1998		2,990					31
32	Roofing, Remodeling		1999		41,517					32
33	Drapes - Main Dining Area		2000		2,735					33
34	Windows - Dining Room		2000		3,620					34
35	Sprinkler Heads		2001		560					35
36	Lights, Call System, Remodeling		1986		67,975					36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Burnsides Community Hlth Ctr

0007153

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

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

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

Facility Name & ID Number Burnsides Community Hlth Ctr

0007153

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

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

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

Facility Name & ID Number Burnsides Community Hlth Ctr

0007153

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

1	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 12B, Carried Forward		\$ 3,826,139	\$		\$	\$	\$	1
2	Concrete driveway and parking lot	2011	17,084						2
3	Install sprinklers	2011	4,056						3
4	Install exhaust fan and hood	2011	10,400						4
5	Install emergency lights	2011	4,017						5
6	Replace gas water heater	2012	22,910						6
7	Install furnace	2012	3,813						7
8	Install new air conditioner	2012	7,308						8
9	Replace air conditioner condenser	2013	2,257						9
10	Install new carpet - F Wing	2013	849						10
11	Replace heat exchanger	2013	1,424						11
12	Purchase new computer server	2012	15,594						12
13	Purchase new floor scrubber	2013	791						13
14	Replace garbage disposal	2013	1,799						14
15	Install Wanderguard system	2013	4,863						15
16									16
17	Walk In Freezer	2014	3,607						17
18	Lighting Retrofit - 14 rooms	2014	12,174						18
19	Acquisition and connection of 3 Milnor commercial dryers	2014	27,529						19
20	Cabling for internet and new wireless system	2014	23,500						20
21									21
22	Lighting Retrofit - 14 rooms-Rebate	2015	(9,131)						22
23	Purchased (2) water holding tanks	2015	13,729						23
24	Room renovation - Rehab Wing - installation of new flooring,	2015	77,982						24
25	closets, valances, painting, acquisition of new furniture								25
26	and revamped plumbing in resident bathrooms								26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,072,694	\$		\$	\$	\$	34

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

Facility Name & ID Number Burnsides Community Hlth Ctr

0007153

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

1	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 12C, Carried Forward		\$ 4,072,694	\$		\$	\$	\$	1
2								2
3 Install new air handler and controllers	2016	68,013						3
4 Replace kitchen air conditioner	2016	7,747						4
5 Resurface parking lot	2016	6,500						5
6 Install (28) new sinks and mounting brackets	2016	12,230						6
7 Repipe power air handler	2016	2,887						7
8 Rebuidl damaged dining room wall	2016	6,704						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30 Depreciation			142,419		142,419			30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,176,775	\$ 142,419		\$ 142,419	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$907,451	\$47,882	\$47,882	\$		\$	71
72	Current Year Purchases	3,594						72
73	Fully Depreciated Assets	141,317						73
74								74
75	TOTALS	\$1,052,362	\$47,882	\$47,882	\$		\$	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77	Local Transport	2004 Ford F150	2011	11,000					
78									
79									
80	TOTALS			\$11,000	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	5,275,476
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	190,301
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	190,301
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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:None
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy:☐ YES☐ NOTerms: *

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

15. Is Movable equipment rental included in building rental?☐ YES☒ NO
16. Rental Amount for movable equipment: \$18,702Description: Dishwasher and copiers
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 149,992	\$		\$ 149,992	1
2	Licensed Speech and Language Development Therapist		hrs			28,158			28,158	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			242,461	122		242,583	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				134,640		134,640	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					11,984			11,984	13
14	TOTAL			\$		\$ 432,595	\$ 134,762		\$ 567,357	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 26,728	\$	1
2	Cash-Patient Deposits	10,050		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	511,598		3
4	Supply Inventory (priced at FIFO)	30,634		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,716		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 598,726	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	170,935		13
14	Buildings, at Historical Cost	4,859,961		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,084,908		16
17	Accumulated Depreciation (book methods)	(4,136,630)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,979,174	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,577,900	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 322,009	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,050		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,384		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,382		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	19,199		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 566,024	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 566,024	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,011,876	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,577,900	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,055,272	1
2	Restatements (describe):		2
3	Adjustment to 2015 Net Income	23,063	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,078,335	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(291,459)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (291,459)	17
	B. Transfers (Itemize):		
18	From Related Organization	225,000	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 225,000	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,011,876	24

* This must agree with page 17, line 47.

Facility Name & ID Number Burnsidess Community Hlth Ctr

0007153

Report Period Beginning: 07/01/15

Ending: 06/30/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,907,879	1
2	Discounts and Allowances for all Levels	(1,330,551)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,577,328	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,328,357	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,328,357	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	245,829	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	927	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 246,756	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,152,445	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	902,813	31
32	Health Care	2,159,083	32
33	General Administration	1,174,283	33
	B. Capital Expense		
34	Ownership	207,725	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,443,904	40
41	Income before Income Taxes (line 30 minus line 40)**	(291,459)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (291,459)	43

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

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,865	1,984	\$ 62,849	\$ 31.68	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,434	8,972	249,889	27.85	3
4	Licensed Practical Nurses	14,433	15,354	351,437	22.89	4
5	CNAs & Orderlies	48,102	51,172	603,004	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,355	3,569	82,936	23.24	8
9	Activity Director					9
10	Activity Assistants	4,610	4,904	69,691	14.21	10
11	Social Service Workers	1,700	1,808	33,176	18.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,527	16,518	194,328	11.76	15
16	Dishwashers					16
17	Maintenance Workers	4,706	5,006	85,903	17.16	17
18	Housekeepers	10,461	11,129	137,819	12.38	18
19	Laundry	4,898	5,211	47,606	9.14	19
20	Administrator	1,955	2,080	76,694	36.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,954	9,526	200,010	21.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,000	137,233	\$ 2,195,342 *	\$ 16.00	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		6,000		36
37	Medical Records Consultant		939		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,689		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		4,677		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 15,305		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Burnsides Community Hlth Ctr

0007153

Report Period Beginning:

07/01/15

Ending:

06/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

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

D. Employee Benefits and Payroll Taxes

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

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

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

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

(1)

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

(2)

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

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

(5)

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

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 5,000 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(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.
This amount is to be recorded on line 42 of Schedule V.

\$ 52,155

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 4,520

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

c.

What percent of all travel expense relates to transportation of nurses and patients?

100%

d.

Have vehicle usage logs been maintained?

Yes

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ 0

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

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

Yes

Burnsides Community Health Center
2016 Cost Report
Supplemental Schedules

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

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

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

<u>Line Item</u>		
Provider Participation Fee	\$	<u>52,155</u>

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

<u>Line Item</u>		
Professional Services - Line 19	\$	<u>(4,583)</u>
Insurance - Prop Liab Malpractice - Line 26	\$	<u>4,583</u>

Reclassifies premium payment erroneously
charged to professional fees account