

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

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 Facility ID Number: 0043398

Facility Name: BURNHAM HEALTHCARE

Address: 14500 S. MANISTEE BURNHAM 60633
 Number City Zip Code

County: COOK

Telephone Number: (708) 862-1260 **Fax #** (708) 862-1263

IDPA ID Number: 36-4205217

Date of Initial License for Current Owners: 03/01/98

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input 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 _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____
	(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____
Paid Preparer	(Title) <u>MEMBER</u>
	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____
Paid Preparer	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>
	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BURNHAM HEALTHCARE

0043398 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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	103	Skilled (SNF)	103	37,595	1
2		Skilled Pediatric (SNF/PED)			2
3	206	Intermediate (ICF)	206	75,190	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	309	TOTALS	309	112,785	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	34,870	560	8,055	43,485	8
9	SNF/PED					9
10	ICF	67,502	118	195	67,815	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	102,372	678	8,250	111,300	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.68%

D. How many bed-hold days during this year were paid by Public Aid? 243 (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 03/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/98 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 30 and days of care provided 7,864

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

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

Facility Name & ID Number **BURNHAM HEALTHCARE** # **0043398** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	300,855	38,026	14,400	353,281		353,281		353,281		1
2	Food Purchase		410,077		410,077	(21,170)	388,907	(2,030)	386,877		2
3	Housekeeping	274,574	57,412		331,986		331,986		331,986		3
4	Laundry	113,593	31,078	10,534	155,205		155,205		155,205		4
5	Heat and Other Utilities			206,489	206,489		206,489	883	207,372		5
6	Maintenance	205,964	44,415	84,410	334,789		334,789	(521)	334,268		6
7	Other (specify):*			32,601	32,601		32,601	64	32,665		7
8	TOTAL General Services	894,986	581,008	348,434	1,824,428	(21,170)	1,803,258	(1,604)	1,801,654		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	3,122,139	134,700	21,924	3,278,763		3,278,763		3,278,763		10
10a	Therapy	112,100	4,232	30,961	147,293		147,293		147,293		10a
11	Activities	121,216	38,611	5,556	165,383		165,383		165,383		11
12	Social Services	183,107		29,562	212,669		212,669		212,669		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,538,562	177,543	94,003	3,810,108		3,810,108		3,810,108		16
	C. General Administration										
17	Administrative	122,985		500,000	622,985		622,985	(384,886)	238,099		17
18	Directors Fees										18
19	Professional Services			143,122	143,122		143,122	3,045	146,167		19
20	Dues, Fees, Subscriptions & Promotions			22,776	22,776		22,776	(5,244)	17,532		20
21	Clerical & General Office Expenses	235,898	33,545	141,718	411,161		411,161	(42,229)	368,932		21
22	Employee Benefits & Payroll Taxes			708,913	708,913	21,170	730,083		730,083		22
23	Inservice Training & Education							62	62		23
24	Travel and Seminar			3,986	3,986		3,986		3,986		24
25	Other Admin. Staff Transportation			7,630	7,630		7,630	1,167	8,797		25
26	Insurance-Prop.Liab.Malpractice			177,994	177,994		177,994	1,552	179,546		26
27	Other (specify):*			410,638	410,638		410,638	(400,399)	10,239		27
28	TOTAL General Administration	358,883	33,545	2,116,777	2,509,205	21,170	2,530,375	(826,932)	1,703,443		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,792,431	792,096	2,559,214	8,143,741		8,143,741	(828,536)	7,315,205		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 PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	14,400
	REPAIRS & MAINTENANCE	0
		0
		14,400
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	10,534
		0
		10,534
5	HEAT & OTHER UTILITIES	
	GAS HEAT	85,899
	ELECTRICITY	76,733
	WATER	43,857
	CABLE TV - LOBBY	0
		0
		206,489
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,705
	PAINTING & DECORATING	6,962
	BUILDING REPAIRS	14,743
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	39,493
	ELEVATOR MAINTENANCE & REPAIR	10,116
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,331
	FIRE SERVICE	5,060
		0
		0
		0
		84,410
7	OTHER	
	SCAVENGER	15,417
	SECURITY SERVICE	17,184
		0
		32,601
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	12,324
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	5,500
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
	PROGRAM CONSULTANT	500
	DENTAL	3,600
		21,924
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	3,821
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	20,642
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	6,417
	SPEECH THERAPY CONSULTANT XVIII B 43-2	81
		30,961
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	5,556
		0
		5,556
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	8,666
	SOCIAL WORKER XVIII B 45-2	20,896
		0
		29,562
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	500,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	17,876
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	125,246
		0
		143,122
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,364
	EMPLOYEE WANT ADS XIX F	3,862
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	11,440
	LICENSES & PERMITS XIX F	1,254
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,856
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		22,776
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,395
	EQUIPMENT REPAIR & MAINTENANCE	4,836
	OUTSIDE CLERICAL SERVICES	83,180
	PENALTIES / OVERDRAFT CHARGES VI 18	7,420
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	34,624
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	7,263
		141,718

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	365,170
	UNEMPLOYMENT COMPENSATION XIX D	42,056
	WORKERS COMPENSATION INSURANCI XIX D	99,304
	HOSPITALIZATION INSURANCE XIX D	138,788
	EMPLOYEE BENEFITS - OTHER XIX D	63,595
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		708,913
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,986
	TRAVEL XIX G	0
		0
		0
		3,986
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,630
		7,630
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	177,994
		177,994
27	OTHER	
	BAD DEBTS VI 24	410,638
		0
		410,638

GRAND TOTAL COLUMN 3 OTHER 2,559,214

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			484,123	484,123		484,123	19,775	503,898		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			1,176,373	1,176,373		1,176,373	84,431	1,260,804		32
33	Real Estate Taxes			624,426	624,426		624,426	77,707	702,133		33
34	Rent-Facility & Grounds			305,806	305,806		305,806	(305,806)			34
35	Rent-Equipment & Vehicles			38,572	38,572		38,572	8,704	47,276		35
36	Other (specify):* amort mort/soft.			118,917	118,917		118,917		118,917		36
37	TOTAL Ownership			2,748,217	2,748,217		2,748,217	(115,189)	2,633,028		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		205,142	203,881	409,023		409,023		409,023		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			169,177	169,177		169,177		169,177		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		205,142	373,058	578,200		578,200		578,200		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,792,431	997,238	5,680,489	11,470,158		11,470,158	(943,725)	10,526,433		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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(12,150)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,030)	2		13
14	Non-Care Related Interest	(16,892)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(7,420)	21		18
19	Entertainment		20		19
20	Contributions	(3,856)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(11,825)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(410,638)	27		24
25	Fund Raising, Advertising and Promotional	(2,364)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(109,051)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (576,226)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(367,499)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (367,499)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (943,725)		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	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BURNHAM HEALTHCARE

ID# 0043398

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (5,802)	6	1
2	STAFF DEVELOPMENT	(7,263)	21	2
3	MARKETING SALARY	(46,591)	21	3
4	BANK CHARGES	(4,395)	21	4
5	MANAGEMENT FEES-P. ESFORMES	(45,000)	17	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	(109,051)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	(2,030)	0	0	0	0	0	0	0	0	0	0	(2,030)	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	883	0	0	0	0	0	0	0	883	5
6	Maintenance	(5,802)	0	3,871	1,410	0	0	0	0	0	0	0	(521)	6
7	Other (specify):*	0	0	64	0	0	0	0	0	0	0	0	64	7
8	TOTAL General Services	(7,832)	0	3,935	2,293	0	(1,604)	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	Nurse Aide 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	(45,000)	(351,727)	11,841	0	0	0	0	0	0	0	0	(384,886)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,825)	300	14,195	375	0	0	0	0	0	0	0	3,045	19
20	Fees, Subscriptions & Promotions	(6,220)	0	976	0	0	0	0	0	0	0	0	(5,244)	20
21	Clerical & General Office Expenses	(65,669)	12,409	10,853	178	0	0	0	0	0	0	0	(42,229)	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	62	0	0	0	0	0	0	0	0	62	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	358	809	0	0	0	0	0	0	0	0	1,167	25
26	Insurance-Prop.Liab.Malpractice	0	278	1,096	178	0	0	0	0	0	0	0	1,552	26
27	Other (specify):*	(410,638)	3,955	6,284	0	0	0	0	0	0	0	0	(400,399)	27
28	TOTAL General Administration	(539,352)	(334,427)	46,116	731	0	(826,932)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(547,184)	(334,427)	50,051	3,024	0	(828,536)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(12,150)	0	430	2,375	29,120	0	0	0	0	0	0	19,775	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,892)	0	0	3,661	97,662	0	0	0	0	0	0	84,431	32
33	Real Estate Taxes	0	0	0	4,554	73,153	0	0	0	0	0	0	77,707	33
34	Rent-Facility & Grounds	0	0	0	(24,102)	(281,704)	0	0	0	0	0	0	(305,806)	34
35	Rent-Equipment & Vehicles	0	1,727	6,755	222	0	0	0	0	0	0	0	8,704	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(29,042)	1,727	7,185	(13,290)	(81,769)	0	0	0	0	0	0	(115,189)	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)	(576,226)	(332,700)	57,236	(10,266)	(81,769)	0	0	0	0	0	0	(943,725)	45

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
SEE ATTACHED		LIST ATTACHED		EKS MNGT	LINCOLNWOOD	MANAGEMENT
				EMI ENTERPRISE	LINCOLNWOOD	CONSULTING
				IME REALTY CORP	LINCOLNWOOD	HOME OFFICE

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	17 MANAGEMENT FEES	\$ 375,000	EMI ENTERPRISE		\$	\$ (375,000)	1
2	V							2
3	V	17 OFFICER'S SALARY				23,273	23,273	3
4	V	19 ACCOUNTING FEES				300	300	4
5	V	21 OFFICE EXPENSE				12,409	12,409	5
6	V	25 TRANSPORTATION				358	358	6
7	V	26 INSURANCE				278	278	7
8	V	27 EMPLOYEE BENEFITS				3,955	3,955	8
9	V	35 AUTO LEASE				1,727	1,727	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 375,000			\$ 42,300	\$ * (332,700)	14

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

VII. RELATED PARTIES (continued)

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)
15	V	21 OUTSIDE CLERICAL	\$ 65,000	EKS MANAGEMENT		\$	\$ (65,000)
16	V						
17	V	6 PAINTING SALARIES				3,871	3,871
18	V	7 SCAVENGER				64	64
19	V	17 C F O SALARY				11,841	11,841
20	V	19 PROFESSIONAL FEES				14,195	14,195
21	V	20 WANT ADS				976	976
22	V	21 OFFICE EXPENSE				75,853	75,853
23	V	23 SEMINARS				62	62
24	V	25 TRANSPORTATION				809	809
25	V	26 INSURANCE				1,096	1,096
26	V	27 EMPLOYEE BENEFITS				6,284	6,284
27	V	30 DEPRECIATION				430	430
28	V	35 EQUIPMENT RENT				6,755	6,755
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 65,000			\$ 122,236	\$ * 57,236

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

VII. RELATED PARTIES (continued)

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)
15	V	34 OFFICE RENT	\$ 24,102	IME REALTY CORP		\$	\$ (24,102)
16	V						
17	V	5 UTILITIES				883	883
18	V	6 REPAIRS/ MAINT				1,410	1,410
19	V	19 PROFESSIONAL FEES				375	375
20	V	21 OFFICE EXPENSE				178	178
21	V	26 INSURANCE				178	178
22	V	30 DEPRECIATION				2,375	2,375
23	V	32 INTEREST				3,661	3,661
24	V	33 R/E TAX				4,554	4,554
25	V	35 STORAGE FEES				222	222
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 24,102			\$ 13,836	\$ * (10,266)

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

VII. RELATED PARTIES (continued)

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)
15	V	34 RENT	\$ 281,704	BURNHAM HEALTH CARE REALTY	100.00%	\$	\$ (281,704) 15
16	V	30 DEPRECIATION		BURNHAM HEALTH CARE REALTY		29,120	29,120 16
17	V	32 INTEREST		BURNHAM HEALTH CARE REALTY		97,662	97,662 17
18	V	33 REAL ESTATE TAXES		BURNHAM HEALTH CARE REALTY		73,153	73,153 18
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 281,704			\$ 199,935	\$ * (81,769) 39

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

Facility Name & ID Number

BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	MORRIS ESFORMES	MEMBER	MANAGEMENT	0.38		See Attached		MNGT FEES	\$ 23,273	17-8	1
2	PHILIP ESFORMES	MEMBER	MANAGEMENT	0.19		See Attached		MNGT FEES	80,000	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 103,273		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 **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2003

Ending: **2/31/2003**

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization EMI ENTERPRISES
 Street Address 6865 N . LINCOLN AVE
 City / State / Zip Code LINCOLNWOOD ,IL.60712
 Phone Number (847)674-1946
 Fax Number (847)674-1962

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	17	OFFICER'S SALARY	PATIENT DAYS	884,739	14	\$ 185,000	\$ 185,000	111,300	\$ 23,273	1
2	19	ACCOUNTING FEES	PATIENT DAYS	884,739	14	2,381		111,300	300	2
3	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	98,637	76,255	111,300	12,409	3
4	25	TRANSPORTATION	PATIENT DAYS	884,739	14	2,845		111,300	358	4
5	26	INSURANCE	PATIENT DAYS	884,739	14	2,209		111,300	278	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	31,442		111,300	3,955	6
7	35	AUTO LEASE	PATIENT DAYS	884,739	14	13,730		111,300	1,727	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					\$ 336,244	\$ 261,255		\$ 42,300	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2003

Ending: **2/31/2003**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARIES	PATIENT DAYS	884,739	14	\$ 30,769	\$ 111,300	\$ 3,871	1
2	7	SCAVENGER	PATIENT DAYS	884,739	14	510	111,300	64	2
3	17	C F O SALARY	PATIENT DAYS	884,739	14	94,128	111,300	11,841	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	884,739	14	112,835	111,300	14,195	4
5	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	884,739	14	7,759	111,300	976	5
6	21	OFFICE	PATIENT DAYS	884,739	14	317,364	111,300	39,924	6
7	23	SEMINARS	PATIENT DAYS	884,739	14	490	111,300	62	7
8	25	TRANSPORTATION	PATIENT DAYS	884,739	14	6,427	111,300	809	8
9	26	INSURANCE	PATIENT DAYS	884,739	14	8,715	111,300	1,096	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	49,951	111,300	6,284	10
11	30	DEPRECIATION	PATIENT DAYS	884,739	14	3,418	111,300	430	11
12	35	EQUIPMENT RENT	PATIENT DAYS	884,739	14	53,700	111,300	6,755	12
13									13
14	21	CLERICAL SALARIES	Direct Allocation			16,354	16,354	16,354	14
15	21	O/S CLERICAL	Direct Allocation			19,575		19,575	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 721,995	\$ 224,532	\$ 122,236	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398 Report Period Beginning: **01/01/2003** Ending: **2/31/2003**

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 IME REALTY CORP
 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	5	UTILITIES	INCOME	303,433	14	\$ 11,111	\$ 24,102	\$ 883	1
2	6	REPAIRS / MAINT	INCOME	303,433	14	17,749	24,102	1,410	2
3	19	PROFESSIONAL FEES	INCOME	303,433	14	4,725	24,102	375	3
4	21	OFFICE EXPENSE	INCOME	303,433	14	2,247	24,102	178	4
5	26	INSURANCE	INCOME	303,433	14	2,237	24,102	178	5
6	30	DEPRECIATION	INCOME	303,433	14	29,895	24,102	2,375	6
7	32	INTEREST	INCOME	303,433	14	46,095	24,102	3,661	7
8	33	R/E TAX	INCOME	303,433	14	57,331	24,102	4,554	8
9	35	STORAGE FEES	INCOME	303,433	14	2,800	24,102	222	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					\$ 174,190	\$	\$ 13,836	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2003

Ending: **2/31/2003**

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 BURNHAM HEALTH CARE REALTY
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD,IL 60712
 Phone Number (847)674-5795
 Fax Number (847)674-5794

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	30	DEPRECIATION	DIRECT COST	1	1	\$ 29,120	\$ 1	\$ 29,120	1
2	32	INTEREST	DIRECT COST	1	1	97,662	1	97,662	2
3	33	REAL ESTATE TAXES	DIRECT COST	1	1	73,153	1	73,153	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					\$ 199,935	\$	\$ 199,935	25

Facility Name & ID Number

BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	COLE TAYLOR BANK		X	MORTGAGE	\$116,941.00	5/24/00	\$ 15,700,000				0.0875	\$ 1,167,431						
2	CAMBRIDGE REALTY		X	MORTGAGE	\$85,698.11	11/21/03	16,088,500	15,913,403				97,662						
3																		
4																		
5	Related Party Allocation											3,661						
Working Capital																		
6	COLE TAYLOR BANK		X	WORKING CAPITAL								8,942						
7																		
8																		
9	TOTAL Facility Related				\$202,639.11		\$ 31,788,500	\$ 15,913,403				\$ 1,277,696						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES														
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$ 31,788,500	\$ 15,913,403				\$ 1,277,696						

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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2002 report.		\$	604,899	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	651,239	2
3. Under or (over) accrual (line 2 minus line 1).		\$	46,340	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	651,239	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	697,579	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	516,010	8
	1999	577,666	9
	2000	586,702	10
	2001	604,899	11
	2002	651,239	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BURNHAM HEALTHCARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043398

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>30-06-313-052-000</u>	<u>NURSING HOME</u>	\$ <u>10,362.86</u>	\$ <u>10,362.86</u>
2. <u>30-06-313-051-000</u>	<u>NURSING HOME</u>	\$ <u>25,742.45</u>	\$ <u>25,742.45</u>
3. <u>30-06-313-040-000</u>	<u>NURSING HOME</u>	\$ <u>527,035.49</u>	\$ <u>527,035.49</u>
4. <u>30-06-313-045-000</u>	<u>NURSING HOME</u>	\$ <u>2,778.37</u>	\$ <u>2,778.37</u>
5. <u>30-06-313-053-000</u>	<u>NURSING HOME</u>	\$ <u>6,820.02</u>	\$ <u>6,820.02</u>
6. <u>30-06-313-054-000</u>	<u>NURSING HOME</u>	\$ <u>78,500.23</u>	\$ <u>78,500.23</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>651,239.42</u>	\$ <u>651,239.42</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2003 Ending:

12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,554 B. General Construction Type: Exterior 3 STORY Frame BRICK Number of Stories 3

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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			1998	\$ 1,500,000	1
2					2
3	TOTALS			\$ 1,500,000	3

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	309		1998		\$ 12,649,700	\$ 314,946	39	\$ 314,946	\$	\$ 1,869,128	4
5											5
6											6
7											7
8	IME ALLOCATION					2,324		2,324			8
	Improvement Type**										
9	ROOF		1998		74,000	1,842	39	1,842		10,462	9
10	WALLCOVERINGS		1998		39,379	980	39	980		5,563	10
11	PAINTING		1998		12,962	322	39	322		1,834	11
12	WINDOW TREATMENTS		1998		38,112	949	39	949		5,386	12
13	FENCE		1998		650	16	39	16		93	13
14	NEW WINDOWS		1998		20,445	509	39	509		2,889	14
15	PAINTERS SALARIES		1998		64,064	1,595	39	1,595		9,057	15
16	NURSE STATION		1998		23,100	575	39	575		3,264	16
17	TILING		1998		635	16	39	16		89	17
18	BUILT IN CABINETS		1998		64,700	1,610	39	1,610		9,022	18
19	NEW COILS FOR AHV		1999		6,000	150	39	150		695	19
20	NEW BOILER		1999		20,328	506	39	506		2,351	20
21	HOT WATER TANK		1999		2,750	69	39	69		320	21
22	ROOF		1999		29,500	733	39	733		3,411	22
23	PATIO		1999		5,080	329	15	329		1,529	23
24	AWNING		1999		3,000	194	15	194		902	24
25	LIGHTS		1999		7,603	189	39	189		880	25
26	NURSE CALL STATION		1999		1,957	49	39	49		226	26
27	WINDOW TREATMENTS		1999		11,207	279	39	279		1,296	27
28	CORRIDOR BORDERS		1999		6,154	154	39	154		713	28
29	SCREENS		2000		3,543	126	27.5	126		454	29
30	AIR CONDITIONER REPLACEMENT		2001		14,540	513	27.5	513		1,328	30
31	DOOR DETECTOR		2001		1,800	64	27.5	64		164	31
32	A/C COMPRESSOR & REBUILT AIR HANDLER		2001		22,621	799	27.5	799		2,068	32
33	ROOF VENTILATORS		2001		6,898	244	27.5	244		631	33
34	BOILER		2001		63,746	2,253	27.5	2,253		5,827	34
35	WALK IN FREEZER		2001		3,750	132	27.5	132		342	35
36	DOOR		2001		2,970	105	27.5	105		271	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

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	DRYER EXHAUST FAN	2001	\$ 4,050	\$ 143	27.5	\$ 143	\$	\$ 370	37
38	DOORS	2001	1,995	70	27.5	70		181	38
39	DOORS	2001	1,723	61	27.5	61		158	39
40	FLOOR TILING & CARPETING	2001	4,497	863	5	899	36	2,697	40
41	DRAPERIES	2001	12,722	2,443	5	2,544	101	7,632	41
42	HOT WATER HEATER & PIPING	2002	19,857	701	27.5	701		1,092	42
43	ROOF	2002	6,150	217	27.5	217		338	43
44	ELECTRIC DOOR LOCKING SYSTEM	2002	2,326	82	27.5	82		128	44
45	DOORS	2002	10,098	356	27.5	356		555	45
46	TILING	2002	17,815	629	27.5	629		980	46
47	SAFETY LOCK SYSTEM	2002	5,854	207	27.5	207		322	47
48	ELEVATOR REPAIR	2002	39,650	1,400	27.5	1,400		2,181	48
49	BOILER	2002	9,550	337	27.5	337		525	49
50	ELEVATOR	2003	100,632	2,064	27.5	2,064		2,064	50
51	PATIO DOORS	2003	2,300	47	27.5	47		47	51
52	FLOORING IN ELEVATORS	2003	1,155	23	27.5	23		23	52
53	NURSES STATION	2003	6,806	140	27.5	140		140	53
54	KITCHEN CABINETS	2003	2,836	59	27.5	59		59	54
55	KITCHEN FLOORING	2003	2,673	55	27.5	55		55	55
56	PATIO TILING & LIGHTING	2003	4,688	96	27.5	96		96	56
57	COVE BASE IN ANNEX CORRIDOR	2003	824	16	27.5	16		16	57
58	HANDRAILS & BUMPER GUARDS	2003	8,565	176	27.5	176		176	58
59	LIGHTING FOR CORRIDORS	2003	1,410	29	27.5	29		29	59
60	KICKPLATES	2003	5,300	108	27.5	108		108	60
61	FREIGHT & SALES TAX ON ABOVE IMPROVEMENTS	2003	816	16	27.5	16		16	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,475,486	\$ 342,910		\$ 343,047	\$ 137	\$ 1,960,183	70

**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	\$ 1,592,676	\$ 162,723	\$ 159,268	\$ (3,455)	10 YRS	\$ 793,017	71
72	Current Year Purchases	22,042	9,934	1,102	(8,832)	10 YRS	1,102	72
73	Fully Depreciated Assets							73
74	IME,EKS ALLOCATION		481	481				74
75	TOTALS	\$ 1,614,718	\$ 173,138	\$ 160,851	\$ (12,287)		\$ 794,119	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 16,590,204	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 516,048	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 503,898	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,150)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,754,302	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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	309		\$			3
4	Additions						4
5							5
6							6
7	TOTAL	309		\$			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: \$ 38,572 Description: SEE SCHEDULE ATTACHED

(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

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. _____ /2004 \$ _____

13. _____ /2005 \$ _____

14. _____ /2006 \$ _____

* 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 NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED AIDES 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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></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 AIDE _____</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 AIDE _____</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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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	\$		\$ 115,783	\$		\$ 115,783	1
2	Licensed Speech and Language Development Therapist		hrs			446			446	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			76,483			76,483	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				198,890		198,890	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): lab, med supplies					11,169	6,252		17,421	13
14	TOTAL			\$		\$ 203,881	\$ 205,142		\$ 409,023	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,283,245	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (200,000))	1,012,893		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	253,487		6
7	Other Prepaid Expenses	345,427		7
8	Accounts Receivable (owners or related parties)	293,199		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,188,251	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	19,318		15
16	Equipment, at Historical Cost	1,636,669		16
17	Accumulated Depreciation (book methods)	(1,347,199)		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)	\$ 308,788	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,497,039	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 670,678	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	286,926		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,936		31
32	Accrued Real Estate Taxes(Sch.IX-B)	578,086		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO PRIOR OWNER</u>	245,489		36
37	<u>DUE TP RELATED PARTIES</u>	215,964		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,029,079	\$	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)	\$ 2,029,079	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,467,960	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,497,039	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 333,860	1
2	Restatements (describe):		2
3	SALE OF ASSETS TO RELATED PARTY	2,190,650	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,524,510	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(159,550)	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	(897,000)	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)	\$ (1,056,550)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,467,960	24 *

* This must agree with page 17, line 47.

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	\$ 11,257,870	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,257,870	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	35,846	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 35,846	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,892	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,892	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)	\$ 11,310,608	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,824,428	31
32	Health Care	3,810,108	32
33	General Administration	2,509,205	33
B. Capital Expense			
34	Ownership	2,748,217	34
C. Ancillary Expense			
35	Special Cost Centers	409,023	35
36	Provider Participation Fee	169,177	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,470,158	40
41	Income before Income Taxes (line 30 minus line 40)**	(159,550)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (159,550)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** 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 BURNHAM HEALTHCARE

0043398

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

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	3,970	4,526	\$ 125,382	\$ 27.70	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,577	27,908	715,086	25.62	3
4	Licensed Practical Nurses	42,967	45,339	879,472	19.40	4
5	Nurse Aides & Orderlies	138,617	145,668	1,179,676	8.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,508	10,248	112,100	10.94	8
9	Activity Director					9
10	Activity Assistants	15,352	16,075	121,216	7.54	10
11	Social Service Workers	14,613	15,766	183,107	11.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,050	39,970	300,855	7.53	15
16	Dishwashers					16
17	Maintenance Workers	17,821	21,354	205,964	9.65	17
18	Housekeepers	35,460	37,274	274,574	7.37	18
19	Laundry	16,032	17,354	113,593	6.55	19
20	Administrator	2,709	2,849	122,985	43.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	5,293	5,293	46,591	8.80	23
24	Clerical	12,482	13,192	135,011	10.23	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	8,334	8,936	63,664	7.12	31
32	Other Health Care(specify)	9,631	10,281	158,859	15.45	32
33	Other(specify) <u>Ward clerk.admiss</u>	2,685	2,696	54,296	20.14	33
34	TOTAL (lines 1 - 33)	400,101	424,729	\$ 4,792,431 *	\$ 11.28	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	monthly fee	\$ 14,400	1-3	35
36	Medical Director	monthly fee	6,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	12,324	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant	404	20,642	10a-3	41
42	Respiratory Therapy Consultant	monthly fee	6,417	10a-3	42
43	Speech Therapy Consultant	monthly fee	81	10a-3	43
44	Activity Consultant	116	5,556	11-3	44
45	Social Service Consultant	monthly fee	29,562	12-3	45
46	Other(specify) <u>physicians</u>	monthly fee	5,500	10-3	46
47	<u>program consultant</u>	monthly fee	500	10-3	47
48	<u>dental</u>	monthly fee	3,600	10-3	48
49	TOTAL (lines 35 - 48)	520	\$ 104,582		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	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	
YOSEF MEYSTEL	ADMIN		\$ 87,345	Workers' Compensation Insurance	\$ 99,304	IDPH License Fee	\$ 200	
FRED BERKOVITS	ADMIN		29,000	Unemployment Compensation Insurance	42,056	Advertising: Employee Recruitment	3,862	
JACOB GRUNFELD	ASST ADMIN		6,640	FICA Taxes	365,170	Health Care Worker Background Check (Indicate # of checks performed _____)	0	
				Employee Health Insurance	138,788	MARKETING/ADV/PROMO	2,364	
				Employee Meals	#REF!	TRUST/FRANCHISE/CONTRIB/ETC	3,856	
				Illinois Municipal Retirement Fund (IMRF)*		LICENSES & PERMITS	1,054	
				EMPLOYEE BENEFITS - OTHER	63,595	DUES & SUBSCRIPTIONS	11,440	
				EMPLOYEE PHYSICAL EXAMS	0	MGMT CO ALLOCATION	976	
				PENSION/PROFIT SHARING PLANS	0	TRUST/FRANCHISE/CONTRIB/ETC	(3,856)	
				CHICAGO HEAD TAX	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE	0	Non-allowable advertising	(2,364)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 122,985	TOTAL (agree to Schedule V, line 22, col.8)	\$ #REF!	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,532	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
EMI ENTERPRISES			\$ 375,000			\$	Out-of-State Travel	\$
PHILIP ESFORMES INC			125,000					
							In-State Travel	0
							Seminar Expense	3,986
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 500,000	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,986
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			143,122					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 143,122					

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2000	FY2001	FY2002	FY2003
1	PAINTING/DECORATING	2003	\$ 6,962	3 yrs	\$	\$	\$	\$ 1,160	\$ 2,321	\$ 2,321	\$ 1,160	\$	\$							
2																				
3																				
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19																				
20	TOTALS		\$ 6,962		\$	\$	\$	\$ 1,160	\$ 2,321	\$ 2,321	\$ 1,160	\$	\$							

Facility Name & ID Number **BURNHAM HEALTHCARE**# **0043398**Report Period Beginning: **01/01/2003**Ending: **12/31/2003****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$11,440
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,622 Line 10-2
- (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 of Public Aid during this cost report period. \$ 169,177
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 of Public Aid, 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. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees