

Facility Name & ID Number BURNHAM HEALTHCARE

0043398 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	35,230	776	14,044	50,050	8
9	SNF/PED					9
10	ICF	60,376	362		60,738	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	95,606	1,138	14,044	110,788	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.23%

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 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 13,395

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: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **BURNHAM HEALTHCARE** # **0043398** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	399,685	43,209	15,660	458,554		458,554		458,554		1
2	Food Purchase		419,537		419,537	(8,979)	410,558	(1,942)	408,616		2
3	Housekeeping	368,615	35,391		404,006		404,006		404,006		3
4	Laundry	145,479	33,185	9,275	187,939		187,939	2,405	190,344		4
5	Heat and Other Utilities			218,047	218,047		218,047	669	218,716		5
6	Maintenance	288,835	46,598	75,649	411,082		411,082	5,911	416,993		6
7	Other (specify):*			29,399	29,399		29,399	143	29,542		7
8	TOTAL General Services	1,202,614	577,920	348,030	2,128,564	(8,979)	2,119,585	7,186	2,126,771		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	3,720,337	160,700	21,205	3,902,242		3,902,242		3,902,242		10
10a	Therapy	126,346	3,907	33,873	164,126		164,126		164,126		10a
11	Activities	154,478	59,038	4,508	218,024		218,024		218,024		11
12	Social Services	226,574		9,066	235,640		235,640		235,640		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,227,735	223,645	74,652	4,526,032		4,526,032		4,526,032		16
	C. General Administration										
17	Administrative	130,357		440,000	570,357		570,357	(229,406)	340,951		17
18	Directors Fees										18
19	Professional Services			85,177	85,177		85,177	22,335	107,512		19
20	Dues, Fees, Subscriptions & Promotions			26,962	26,962		26,962	(2,256)	24,706		20
21	Clerical & General Office Expenses	221,364	33,104	119,732	374,200		374,200	(54,918)	319,282		21
22	Employee Benefits & Payroll Taxes			960,247	960,247	8,979	969,226		969,226		22
23	Inservice Training & Education							47	47		23
24	Travel and Seminar			4,832	4,832		4,832		4,832		24
25	Other Admin. Staff Transportation			11,194	11,194		11,194	947	12,141		25
26	Insurance-Prop.Liab.Malpractice			138,860	138,860		138,860	32,174	171,034		26
27	Other (specify):*			1,738,213	1,738,213		1,738,213	(1,725,876)	12,337		27
28	TOTAL General Administration	351,721	33,104	3,525,217	3,910,042	8,979	3,919,021	(1,956,953)	1,962,068		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,782,070	834,669	3,947,899	10,564,638		10,564,638	(1,949,767)	8,614,871		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	15,660
	REPAIRS & MAINTENANCE		0
			0
			15,660
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		9,275
			0
			9,275
5	HEAT & OTHER UTILITIES		
	GAS HEAT		100,126
	ELECTRICITY		77,846
	WATER		40,075
	CABLE TV - LOBBY		0
			0
			218,047
6	MAINTENANCE		
	GROUNDS MAINTENANCE		4,844
	PAINTING & DECORATING		2,333
	BUILDING REPAIRS		8,131
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		38,892
	ELEVATOR MAINTENANCE & REPAIR		11,792
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		4,716
	FIRE SERVICE		4,941
			0
			0
			75,649
7	OTHER		
	SCAVENGER		18,390
	SECURITY SERVICE		11,009
			29,399
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	11,305
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	6,000
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	DENTAL CONSULTANT		3,900
			0
			21,205
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		29,688
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	285
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,007
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	1,080
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	813
			33,873
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,032
	PROGRAM CONSULTANT		476
			4,508
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	9,066
	SOCIAL WORKER	XVIII B 45-2	0
			0
			9,066
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	440,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	20,798
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	64,379
		0
		85,177
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	4,563
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	12,786
	LICENSES & PERMITS XIX F	5,663
	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	3,950
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		26,962
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	104
	EQUIPMENT REPAIR & MAINTENANCE	5,169
	OUTSIDE CLERICAL SERVICES	72,000
	PENALTIES / OVERDRAFT CHARGES VI 18	6,491
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	28,450
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	7,518
		119,732

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	436,430
	UNEMPLOYMENT COMPENSATION XIX D	125,437
	WORKERS COMPENSATION INSURANCE XIX D	181,446
	HOSPITALIZATION INSURANCE XIX D	161,549
	EMPLOYEE BENEFITS - OTHER XIX D	2,083
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	53,302
	CHICAGO HEAD TAX XIX D	0
		960,247
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	4,832
	TRAVEL XIX G	0
		0
		0
		4,832
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	11,194
		11,194
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	138,860
		138,860
27	OTHER	
	BAD DEBTS VI 24	1,738,213
		1,738,213

GRAND TOTAL COLUMN 3 OTHER

3,947,899

BURNHAM HEALTHCARE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	419,537	PATIENT MEALS	332364
LESS SALES TAX	(1,942)	ADD EMPLOYEE MEALS	7300
	-----		-----
NET FOOD	417,595	TOTAL MEALS/YEAR	339664
TOTAL PATIENT CENSUS	110,788	NET FOOD	417595
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	339664

TOTAL PATIENT MEALS	332364	COST PER MEAL	1.23
		TIME EMPLOYEE MEALS	7300
ADD # EMPLOYEE MEALS/DAY	20		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	8979
	-----		=====
TOTAL EMPLOYEE MEALS	7300		

Facility Name & ID Number

BURNHAM HEALTHCARE

#0043398

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			112,850	112,850		112,850	411,851	524,701			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,950	14,950		14,950	846,411	861,361			32
33	Real Estate Taxes							756,800	756,800			33
34	Rent-Facility & Grounds			1,886,500	1,886,500		1,886,500	(1,886,500)				34
35	Rent-Equipment & Vehicles			44,658	44,658		44,658	9,006	53,664			35
36	Other (specify):* amort software/ime rent			31,419	31,419		31,419	(24,102)	7,317			36
37	TOTAL Ownership			2,090,377	2,090,377		2,090,377	113,466	2,203,843			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		389,540	684,107	1,073,647		1,073,647		1,073,647			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,178	169,178		169,178		169,178			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		389,540	853,285	1,242,825		1,242,825		1,242,825			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,782,070	1,224,209	6,891,561	13,897,840		13,897,840	(1,836,301)	12,061,539			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	59,833	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	(1,942)	2		13
14	Non-Care Related Interest		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	(6,491)	21		18
19	Entertainment		20		19
20	Contributions	(3,950)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,738,213)	27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(30,186)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,720,949)		\$	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)	(115,352)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (115,352)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,836,301)		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: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,398	6	1
2	MARKETING SALARY	(24,066)	21	2
3	STAFF DEVELOPMENT	(7,518)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(30,186)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398

Report Period Beginning:

01/01/2005

Ending:

12/31/2005**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	(1,942)	0	0	0	0	0	0	0	0	0	0	(1,942)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	2,405	0	0	0	0	0	0	0	0	2,405	4
5	Heat and Other Utilities	0	0	0	669	0	0	0	0	0	0	0	669	5
6	Maintenance	1,398	0	3,185	1,328	0	0	0	0	0	0	0	5,911	6
7	Other (specify):*	0	0	70	73	0	0	0	0	0	0	0	143	7
8	TOTAL General Services	(544)	0	5,660	2,070	0	0	0	0	0	0	0	7,186	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	(242,271)	12,865	0	0	0	0	0	0	0	0	(229,406)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	826	18,399	110	3,000	0	0	0	0	0	0	22,335	19
20	Fees, Subscriptions & Promotions	(3,950)	0	1,694	0	0	0	0	0	0	0	0	(2,256)	20
21	Clerical & General Office Expenses	(38,075)	12,018	(29,394)	533	0	0	0	0	0	0	0	(54,918)	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	47	0	0	0	0	0	0	0	0	47	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	137	810	0	0	0	0	0	0	0	0	947	25
26	Insurance-Prop.Liab.Malpractice	0	340	3,796	404	27,634	0	0	0	0	0	0	32,174	26
27	Other (specify):*	(1,738,213)	3,685	8,652	0	0	0	0	0	0	0	0	(1,725,876)	27
28	TOTAL General Administration	(1,780,238)	(225,265)	16,869	1,047	30,634	0	0	0	0	0	0	(1,956,953)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,780,782)	(225,265)	22,529	3,117	30,634	0	0	0	0	0	0	(1,949,767)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	59,833	0	444	2,119	349,455	0	0	0	0	0	0	411,851	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	3,515	842,896	0	0	0	0	0	0	846,411	32
33	Real Estate Taxes	0	0	0	3,296	753,504	0	0	0	0	0	0	756,800	33
34	Rent-Facility & Grounds	0	0	0	0	(1,886,500)	0	0	0	0	0	0	(1,886,500)	34
35	Rent-Equipment & Vehicles	0	690	7,844	472	0	0	0	0	0	0	0	9,006	35
36	Other (specify):*	0	0	0	(24,102)	0	0	0	0	0	0	0	(24,102)	36
37	TOTAL Ownership	59,833	690	8,288	(14,700)	59,355	0	0	0	0	0	0	113,466	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)	(1,720,949)	(224,575)	30,817	(11,583)	89,989	0	0	0	0	0	0	(1,836,301)	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
				EKS MNGT	LINCOLNWOOD	MANAGEMENT
				EMI ENTERPRISE	LINCOLNWOOD	CONSULTING
				IME REALTY CORP	LINCOLNWOOD	HOME OFFICE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

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	\$ 295,000	EMI ENTERPRISE		\$	\$(295,000)	1
2	V								2
3	V	17	OFFICER'S SALARY			52,729		52,729	3
4	V	19	ACCOUNTING FEES			826		826	4
5	V	21	OFFICE EXPENSE			12,018		12,018	5
6	V	25	TRANSPORTATION			137		137	6
7	V	26	INSURANCE			340		340	7
8	V	27	EMPLOYEE BENEFITS			3,685		3,685	8
9	V	35	AUTO LEASE			690		690	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 295,000			\$ 70,425	\$ *	\$(224,575)	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	\$ 72,000	EKS MANAGEMENT		\$ (72,000)
16	V						
17	V	4	HOUSEKEEPING SALARIES			2,388	2,388
18	V	4	CLEANING SUPPLIES			17	17
19	V	6	PAINTING SALARIES			3,185	3,185
20	V	7	SCAVENGER			70	70
21	V	17	C F O SALARY			12,865	12,865
22	V	19	PROFESSIONAL FEES			18,399	18,399
23	V	20	WANT ADS			1,694	1,694
24	V	21	OFFICE EXPENSE			42,606	42,606
25	V	23	SEMINARS			47	47
26	V	25	TRANSPORTATION			810	810
27	V	26	INSURANCE			3,796	3,796
28	V	27	EMPLOYEE BENEFITS			8,652	8,652
29	V	30	DEPRECIATION			444	444
30	V	35	EQUIPMENT RENT			7,844	7,844
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 72,000			\$ 102,817	\$ * 30,817

* 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	36 OFFICE RENT	\$ 24,102	IME REALTY CORP		\$	\$ (24,102)
16	V						
17	V	5 UTILITIES				669	669
18	V	6 REPAIRS/ MAINT				1,328	1,328
19	V	7 ALARM SERVICE				73	73
20	V	19 PROFESSIONAL FEES				110	110
21	V	21 OFFICE EXPENSE				533	533
22	V	26 INSURANCE				404	404
23	V	30 DEPRECIATION				2,119	2,119
24	V	32 INTEREST				3,515	3,515
25	V	33 R/E TAX				3,296	3,296
26	V	35 STORAGE FEES				472	472
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			\$ 12,519	\$ * (11,583)

* 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	\$ 1,886,500	BURNHAM HEALTH CARE REALTY		\$	(1,886,500)
16	V	30 DEPRECIATION		BURNHAM HEALTH CARE REALTY		349,455	349,455
17	V	32 INTEREST		BURNHAM HEALTH CARE REALTY		842,896	842,896
18	V	33 REAL ESTATE TAXES		BURNHAM HEALTH CARE REALTY		753,504	753,504
19	V	19 PROFESSIONAL FEES		BURNHAM HEALTH CARE REALTY		3,000	3,000
20	V	26 INSURANCE		BURNHAM HEALTH CARE REALTY		27,634	27,634
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		\$ 1,886,500			\$ 1,976,489	\$ * 89,989

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

Facility Name & ID Number

BURNHAM HEALTHCARE

#

0043398

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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		MNGT FEES	\$ 52,729	17-8	1
2	PHILIP ESFORMES	MEMBER	MANAGEMENT	0.19		ATTACHED		MNGT FEES	145,000	17-8	2
3	AVRUM WEINFELD	CFO	FIN. OFFICER			SCHEDULE		SALARY	12,865	17-8	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 210,594		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:

01/01/2005

Ending: **2/31/2005**

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 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

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	901,761	15	\$ 185,000	\$ 110,788	\$ 22,729	1
2	19	ACCOUNTING FEES	PATIENT DAYS	901,761	15	6,725	110,788	826	2
3	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	97,823	110,788	12,018	3
4	25	TRANSPORTATION	PATIENT DAYS	901,761	15	1,114	110,788	137	4
5	26	INSURANCE	PATIENT DAYS	901,761	15	2,768	110,788	340	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	29,997	110,788	3,685	6
7	35	AUTO LEASE	PATIENT DAYS	901,761	15	5,617	110,788	690	7
8	17	OFFICER'S SALARY	DIRECT	1	1	30,000	1	30,000	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					\$ 359,044	\$ 294,576	\$ 70,425	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2005

Ending: **2/31/2005**

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 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	4	HOUSEKEEPING SALARIES	PATIENT DAYS	901,761	15	\$ 19,441	\$ 110,788	\$ 2,388	1
2	4	CLEANING SUPPLIES	PATIENT DAYS	901,761	15	140	110,788	17	2
3	6	PAINTERS SALARIES	PATIENT DAYS	901,761	15	25,925	110,788	3,185	3
4	7	SCAVENGER	PATIENT DAYS	901,761	15	573	110,788	70	4
5	17	C F O SALARY	PATIENT DAYS	901,761	15	104,714	110,788	12,865	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	901,761	15	149,759	110,788	18,399	6
7	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	901,761	15	13,787	110,788	1,694	7
8	21	OFFICE	PATIENT DAYS	901,761	15	346,792	110,788	42,606	8
9	23	SEMINARS	PATIENT DAYS	901,761	15	380	110,788	47	9
10	25	TRANSPORTATION	PATIENT DAYS	901,761	15	6,593	110,788	810	10
11	26	INSURANCE	PATIENT DAYS	901,761	15	30,900	110,788	3,796	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	70,423	110,788	8,652	12
13	30	DEPRECIATION	PATIENT DAYS	901,761	15	3,617	110,788	444	13
14	35	EQUIPMENT RENT	PATIENT DAYS	901,761	15	63,848	110,788	7,844	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 836,892	\$ 399,009	\$ 102,817	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2005

Ending: **2/31/2005**

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 IME REALTY CORP.
 Street Address 6865 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 675-5794

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	5	UTILITIES	INCOME	346,361	15	\$ 9,618	\$ 24,102	\$ 669	1
2	6	REPAIRS / MAINT	INCOME	346,361	15	19,083	24,102	1,328	2
3	7	ALARM SERVICE	INCOME	346,361	15	1,056	24,102	73	3
4	19	PROFESSIONAL FEES	INCOME	346,361	15	1,575	24,102	110	4
5	21	OFFICE EXPENSE	INCOME	346,361	15	7,666	24,102	533	5
6	26	INSURANCE	INCOME	346,361	15	5,806	24,102	404	6
7	30	DEPRECIATION	INCOME	346,361	15	30,446	24,102	2,119	7
8	32	INTEREST	INCOME	346,361	15	50,514	24,102	3,515	8
9	33	R/E TAX	INCOME	346,361	15	47,364	24,102	3,296	9
10	35	STORAGE FEES	INCOME	346,361	15	6,785	24,102	472	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					\$ 179,913	\$	\$ 12,519	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398 Report Period Beginning: **01/01/2005** Ending: **2/31/2005**

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 BURNHAM HEALTH CARE REALTY
 Street Address 6865 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 675-5794

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	30	DEPRECIATION	DIRECT COST	1	1	\$ 349,455	\$ 1	\$ 349,455	1
2	32	INTEREST	DIRECT COST	1	1	842,896	1	842,896	2
3	33	REAL ESTATE TAXES	DIRECT COST	1	1	753,504	1	753,504	3
4	19	PROFESSIONAL FEES	DIRECT COST	1	1	3,000	1	3,000	4
5	26	INSURANCE	DIRECT COST	1	1	27,634	1	27,634	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					\$ 1,976,489	\$	\$ 1,976,489	25

Facility Name & ID Number

BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	CAMBRIDGE REALTY		X	MORTGAGE	\$85,698.11	11/21/03	\$ 16,088,500	\$ 15,533,995	9/1/37	0.0533	\$ 842,896	1						
2												2						
3												3						
4												4						
5	RELATED PARTY	X									3,515	5						
Working Capital																		
6	LASALLE BANK		X	WORKING CAPITAL	INT ONLY						14,950	6						
7												7						
8												8						
9	TOTAL Facility Related				\$85,698.11		\$ 16,088,500	\$ 15,533,995			\$ 861,361	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 16,088,500	\$ 15,533,995			\$ 861,361	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 2004 report.		\$	723,923	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.)		\$	720,502	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,421)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	756,925	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.		\$	753,504	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	586,702	8
	2001	604,899	9
	2002	651,239	10
	2003	689,451	11
	2004	720,502	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 105% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 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 2004 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 2004.

(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>30-06-313-040-000</u>	<u>NURSING HOME</u>	\$ <u>583,088.53</u>	\$ <u>583,088.53</u>
2. <u>30-06-313-045-000</u>	<u>NURSING HOME</u>	\$ <u>3,073.86</u>	\$ <u>3,073.86</u>
3. <u>30-06-313-051-000</u>	<u>NURSING HOME</u>	\$ <u>28,480.30</u>	\$ <u>28,480.30</u>
4. <u>30-06-313-052-000</u>	<u>NURSING HOME</u>	\$ <u>11,464.99</u>	\$ <u>11,464.99</u>
5. <u>30-06-313-053-000</u>	<u>NURSING HOME</u>	\$ <u>7,545.30</u>	\$ <u>7,545.30</u>
6. <u>30-06-313-054-000</u>	<u>NURSING HOME</u>	\$ <u>86,849.11</u>	\$ <u>86,849.11</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>720,502.09</u>	\$ <u>720,502.09</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 original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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, CNA 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:

01/01/2005 Ending: 12/31/2005

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	\$ 324,351	39	\$ 324,351	\$	\$ 2,517,830	4
5										5
6										6
7	RELATED PARTIES ALLOCATION			71,100	2,036		2,036			7
8										8
	Improvement Type**									
9	ROOF - REALTY	1998		74,000	1,897	39	1,897		14,256	9
10	WALLCOVERINGS - REALTY	1998		39,379	1,010	39	1,010		7,583	10
11	PAINTING - REALTY	1998		12,962	332	39	332		2,498	11
12	WINDOW TREATMENTS - REALTY	1998		38,112	977	39	977		7,340	12
13	FENCE - REALTY	1998		650	17	39	17		127	13
14	NEW WINDOWS - REALTY	1998		20,445	524	39	524		3,937	14
15	PAINTERS SALARIES - REALTY	1998		64,064	1,643	39	1,643		12,343	15
16	NURSE STATION - REALTY	1998		23,100	592	39	592		4,448	16
17	TILING - REALTY	1998		635	17	39	17		123	17
18	BUILT IN CABINETS - REALTY	1998		64,700	1,659	39	1,659		12,340	18
19	NEW COILS FOR AHV - REALTY	1999		6,000	154	39	154		1,003	19
20	NEW BOILER - REALTY	1999		20,328	521	39	521		3,393	20
21	HOT WATER TANK - REALTY	1999		2,750	71	39	71		462	21
22	ROOF - REALTY	1999		29,500	756	39	756		4,923	22
23	PATIO - REALTY	1999		5,080	339	15	329	(10)	2,187	23
24	AWNING - REALTY	1999		3,000	200	15	194	(6)	1,290	24
25	LIGHTS - REALTY	1999		7,603	195	39	195		1,270	25
26	NURSE CALL STATION - REALTY	1999		1,957	50	39	50		326	26
27	WINDOW TREATMENTS - REALTY	1999		11,207	287	39	287		1,870	27
28	CORRIDOR BORDERS - REALTY	1999		6,154	158	39	158		1,029	28
29	SCREENS - REALTY	2000		3,543	129	27.5	129		712	29
30	AIR CONDITIONER REPLACEMENT - REALTY	2001		14,540	529	27.5	529		2,386	30
31	DOOR DETECTOR - REALTY	2001		1,800	65	27.5	65		294	31
32	A/C COMPRESSOR & REBUILT AIR HANDLER - REALTY	2001		22,621	823	27.5	823		3,714	32
33	ROOF VENTILATORS - REALTY	2001		6,898	251	27.5	251		1,133	33
34	BOILER - REALTY	2001		63,746	2,318	27.5	2,318		10,463	34
35	WALK IN FREEZER - REALTY	2001		3,750	136	27.5	136		614	35
36	DOOR - REALTY	2001		2,970	108	27.5	108		487	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:

01/01/2005 Ending: 12/31/2005

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 - REALTY	2001	\$ 4,050	\$ 147	27.5	\$ 147	\$	\$ 664	37
38	DOORS - REALTY	2001	1,995	72	27.5	72		325	38
39	DOORS - REALTY	2001	1,723	63	27.5	63		284	39
40	FLOOR TILING & CARPETING	2001	4,497	518	5	901	383	4,497	40
41	DRAPERIES	2001	12,722	1,466	5	2,546	1,080	12,722	41
42	HOT WATER HEATER & PIPING - REALTY	2002	19,857	722	27.5	722		2,536	42
43	ROOF - REALTY	2002	6,150	224	27.5	224		786	43
44	ELECTRIC DOOR LOCKING SYSTEM - REALTY	2002	2,326	84	27.5	84		296	44
45	DOORS - REALTY	2002	10,098	367	27.5	367		1,289	45
46	TILING - REALTY	2002	17,815	648	27.5	648		2,276	46
47	SAFETY LOCK SYSTEM - REALTY	2002	5,854	213	27.5	213		748	47
48	ELEVATOR REPAIR - REALTY	2002	39,650	1,442	27.5	1,442		5,065	48
49	BOILER - REALTY	2002	9,550	347	27.5	347		1,219	49
50	ELEVATOR - REALTY	2003	100,632	3,659	27.5	3,659		9,382	50
51	PATIO DOORS - REALTY	2003	2,300	84	27.5	84		215	51
52	FLOORING IN ELEVATORS - REALTY	2003	1,155	42	27.5	42		107	52
53	NURSES STATION - REALTY	2003	6,806	247	27.5	247		634	53
54	KITCHEN CABINETS - REALTY	2003	2,836	103	27.5	103		265	54
55	KITCHEN FLOORING - REALTY	2003	2,673	97	27.5	97		249	55
56	PATIO TILING & LIGHTING - REALTY	2003	4,688	170	27.5	170		436	56
57	COVE BASE IN ANNEX CORRIDOR - REALTY	2003	824	30	27.5	30		76	57
58	HANDRAILS & BUMPER GUARDS - REALTY	2003	8,565	311	27.5	311		798	58
59	LIGHTING FOR CORRIDORS - REALTY	2003	1,410	51	27.5	51		131	59
60	KICKPLATES - REALTY	2003	5,300	193	27.5	193		494	60
61	FREIGHT & SALES TAX ON ABOVE IMP. - REALTY	2003	816	30	27.5	30		76	61
62	DOOR ALARM SYSTEM	2004	3,076	112	27.5	112		173	62
63	NEW FLOORING	2004	39,141	1,423	27.5	1,423		2,194	63
64	AIR CONDITIONING CHILLER UNIT	2004	14,876	541	27.5	541		834	64
65	TILE FLOORING	2004	4,031	147	27.5	147		226	65
66	FIRE SUPPRESSION SYSTEMS	2004	5,001	182	27.5	182		280	66
67	SHOWER, BATH & TUB ROOMS AND KITCHEN	2004	72,837	2,649	27.5	2,649		4,084	67
68	AIR CONDITIONING UNIT	2004	5,484	199	27.5	199		307	68
69	POWER ROOF EXHAUST UNITS	2005	3,972	30	27.5	30		30	69
70	TOTAL (lines 4 thru 69)		\$ 13,695,004	\$ 358,758		\$ 360,205	\$ 1,447	\$ 2,674,079	70

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 13,695,004	\$ 358,758		\$ 360,205	\$ 1,447	\$ 2,674,079	1
2	2005	1,770	14	27.5	14		14	2
3	2005	3,545	27	27.5	27		27	3
4	2005	11,800	89	27.5	89		89	4
5	2005	3,784	757	5	378	(379)	378	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		\$ 13,715,903	\$ 359,645		\$ 360,713	\$ 1,068	\$ 2,674,587	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,624,990	\$ 100,847	\$ 162,499	\$ 61,652		\$ 1,118,604	71
72	Current Year Purchases	19,247	3,849	962	(2,887)		962	72
73	Fully Depreciated Assets							73
74	RELATED PARTIES		527	527				74
75	TOTALS	\$ 1,644,237	\$ 105,223	\$ 163,988	\$ 58,765		\$ 1,119,566	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)	\$ 16,860,140	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 464,868	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 524,701	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 59,833	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,794,153	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		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: \$ 44,658 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. _____/2006 \$ _____

13. _____/2007 \$ _____

14. _____/2008 \$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	\$		\$ 396,310	\$		\$ 396,310	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			918			918	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			286,879			286,879	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				368,686		368,686	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): med supplies, lab	39-8					20,854		20,854	13
14	TOTAL			\$		\$ 684,107	\$ 389,540		\$ 1,073,647	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.

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(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	\$ 192,435	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (300,000))	1,056,584		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	174,820		6
7	Other Prepaid Expenses	1,118		7
8	Accounts Receivable (owners or related parties)	354,190		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,779,147	\$	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	165,533		15
16	Equipment, at Historical Cost	1,687,191		16
17	Accumulated Depreciation (book methods)	(1,637,362)		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)	\$ 215,362	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,994,509	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 405,707	\$	26
27	Officer's Accounts Payable	620,310		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	171,541		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,719		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	DUE TO RELATED PARTIES	221,864		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,452,141	\$	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)	\$ 1,452,141	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 542,368	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,994,509	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,543,306	1
2	Restatements (describe):		2
3	POSTCLOSING ENTRIES	(6,998)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,536,308	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	12,060	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	(1,006,000)	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)	\$ (993,940)	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)	\$ 542,368	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	\$ 13,745,015	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,745,015	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	165,359	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 165,359	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		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***	922	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 922	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR EXPENSE	(1,396)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1,396)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,909,900	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,128,564	31
32	Health Care	4,526,032	32
33	General Administration	3,910,042	33
	B. Capital Expense		
34	Ownership	2,090,377	34
	C. Ancillary Expense		
35	Special Cost Centers	1,073,647	35
36	Provider Participation Fee	169,178	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,897,840	40
41	Income before Income Taxes (line 30 minus line 40)**	12,060	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 12,060	43

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

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

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

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

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	3,827	4,473	\$ 139,757	\$ 31.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,976	25,499	685,278	26.87	3
4	Licensed Practical Nurses	49,197	51,998	1,109,298	21.33	4
5	CNAs & Orderlies	149,048	170,203	1,542,247	9.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,662	10,605	126,346	11.91	8
9	Activity Director					9
10	Activity Assistants	17,336	18,708	154,478	8.26	10
11	Social Service Workers	15,903	17,088	226,574	13.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,737	45,336	399,685	8.82	15
16	Dishwashers					16
17	Maintenance Workers	29,247	30,617	288,835	9.43	17
18	Housekeepers	38,237	43,801	368,615	8.42	18
19	Laundry	16,201	19,025	145,479	7.65	19
20	Administrator	2,086	2,290	130,357	56.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,086	2,086	24,066	11.54	23
24	Clerical	12,059	13,099	145,315	11.09	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	2,096	2,421	24,672	10.19	31
32	Other Health C: <u>MDS,QA,Data ent</u>	6,857	7,613	157,512	20.69	32
33	Other(specify) <u></u>	10,926	11,740	113,556	9.67	33
34	TOTAL (lines 1 - 33)	428,481	476,602	\$ 5,782,070 *	\$ 12.13	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	\$ 15,660	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	11,305	10-3	39
40	Physical Therapy Consultant	monthly fee	285	10a-3	40
41	Occupational Therapy Consultant	monthly fee	2,007	10a-3	41
42	Respiratory Therapy Consultant	monthly fee	1,080	10a-3	42
43	Speech Therapy Consultant	monthly fee	813	10a-3	43
44	Activity Consultant	monthly fee	4,032	11-3	44
45	Social Service Consultant	monthly fee	9,066	12-3	45
46	Other(specify) <u>Physician</u>	monthly fee	6,000	10-3	46
47	<u>Program Consultant</u>	monthly fee	476	11-3	47
48	<u>Dental Consultant</u>	monthly fee	3,900	10-3	48
49	TOTAL (lines 35 - 48)		\$ 60,624		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0	10-3	50
51	Licensed Practical Nurses	0	10-3	51
52	Certified Nurse Assistants/Aides	0	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	
FRED BERKOVITS	ADMIN		\$ 130,357	Workers' Compensation Insurance	\$ 181,446	IDPH License Fee	\$ 1,990	
	ASST ADMIN		0	Unemployment Compensation Insurance	125,437	Advertising: Employee Recruitment	4,563	
				FICA Taxes	436,430	Health Care Worker Background Check	0	
				Employee Health Insurance	161,549	(Indicate # of checks performed)		
				Employee Meals	8,979	MARKETING/ADV/PROMO	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	3,950	
				EMPLOYEE BENEFITS - OTHER	2,083	LICENSES & PERMITS	3,673	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	12,786	
				PENSION/PROFIT SHARING PLANS	53,302	MGMT CO ALLOCATION	1,694	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(3,950)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(0)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 130,357	TOTAL (agree to Schedule V, line 22, col.8)	\$ 969,226	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,706	
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			\$ 295,000				Out-of-State Travel	\$
PHILIP ESFORMES, INC			145,000				In-State Travel	0
							Seminar Expense	4,832
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 440,000	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,832
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			85,177					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 85,177					

* 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	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATING	2003	\$ 6,962	3 YRS	\$	\$ 1,160	\$ 2,321	\$ 2,321	\$ 1,160	\$	\$	\$								
2	PAINT/DECORATING	2004	3,092	3 YRS			515	1,031	1,031	515										
3	PAINT/DECORATING	2005	2,333	3 YRS				379	788	788	378									
4																				
5																				
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20	TOTALS		\$ 12,387		\$	\$ 1,160	\$ 2,836	\$ 3,731	\$ 2,979	\$ 1,303	\$ 378	\$								

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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: \$12,736
- (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. \$ 96 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 _____ 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. \$ 169,178
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 8,979 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. \$ N/A
- (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