



Facility Name & ID Number BURNHAM HEALTHCARE

# 0043398 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	20,644	27	5,108	25,779	8
9	SNF/PED					9
10	ICF	84,078	295	662	85,035	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	104,722	322	5,770	110,814	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.25%

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 \_\_\_\_\_ 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 5,108

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **BURNHAM HEALTHCARE** # **0043398** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	392,028	53,361	15,660	461,049		461,049		461,049		1
2	Food Purchase		437,942		437,942		437,942	(2,204)	435,738		2
3	Housekeeping	404,055	40,852		444,907		444,907		444,907		3
4	Laundry	126,380	25,077	8,745	160,202		160,202	2,519	162,721		4
5	Heat and Other Utilities			229,390	229,390		229,390	665	230,055		5
6	Maintenance	91,478	65,409	78,936	235,823		235,823	11,829	247,652		6
7	Other (specify):* <b>SECURITY</b>	183,866		35,367	219,233		219,233	140	219,373		7
8	<b>TOTAL General Services</b>	1,197,807	622,641	368,098	2,188,546		2,188,546	12,949	2,201,495		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	3,649,821	181,118	15,084	3,846,023		3,846,023	2,447	3,848,470		10
10a	Therapy	135,185	55	557	135,797		135,797		135,797		10a
11	Activities	165,180	59,272	392	224,844		224,844		224,844		11
12	Social Services	243,159		4,046	247,205		247,205		247,205		12
13	CNA Training										13
14	Program Transportation			1,257	1,257		1,257		1,257		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,193,345	240,445	27,336	4,461,126		4,461,126	2,447	4,463,573		16
	<b>C. General Administration</b>										
17	Administrative	130,357		89,000	219,357		219,357	(4,480)	214,877		17
18	Directors Fees										18
19	Professional Services			53,472	53,472		53,472	28,812	82,284		19
20	Dues, Fees, Subscriptions & Promotions			24,576	24,576		24,576	(1,637)	22,939		20
21	Clerical & General Office Expenses	231,748	40,735	37,481	309,964		309,964	27,898	337,862		21
22	Employee Benefits & Payroll Taxes			929,778	929,778		929,778		929,778		22
23	Inservice Training & Education							85	85		23
24	Travel and Seminar			1,987	1,987		1,987		1,987		24
25	Other Admin. Staff Transportation			15,334	15,334		15,334	1,806	17,140		25
26	Insurance-Prop.Liab.Malpractice			170,184	170,184		170,184	31,036	201,220		26
27	Other (specify):*			407,512	407,512		407,512	(386,481)	21,031		27
28	<b>TOTAL General Administration</b>	362,105	40,735	1,729,324	2,132,164		2,132,164	(302,961)	1,829,203		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,753,257	903,821	2,124,758	8,781,836		8,781,836	(287,565)	8,494,271		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	15,660
	REPAIRS & MAINTENANCE	0
		0
		15,660
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	8,745
		0
		8,745
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	78,153
	ELECTRICITY	104,602
	WATER	45,661
	CABLE TV - LOBBY	974
		0
		229,390
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	6,348
	PAINTING & DECORATING	0
	BUILDING REPAIRS	6,974
	MAINTENANCE TRAVEL	32,344
	EQUIPMENT MAINTENANCE & REPAIR	15,426
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	5,858
	FIRE SERVICE	7,657
	PAINTING & DECORATING	4,329
		0
		0
		0
		78,936
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	24,363
	SECURITY SERVICE	11,004
		0
		0
		35,367
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	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	5,099
	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	3,985
		0
		15,084
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	428
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	29
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	100
		557
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	392
		0
		392
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	4,046
	SOCIAL WORKER XVIII B 45-2	0
		0
		4,046
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	1,257
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	89,000
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	25,447
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	28,025
		0
		53,472
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,434
	EMPLOYEE WANT ADS XIX F	1,223
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	12,747
	LICENSES & PERMITS XIX F	4,233
	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	3,939
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		24,576
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	5,636
	OUTSIDE CLERICAL SERVICES	11,000
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	19,438
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	1,407
		37,481

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	432,098
	UNEMPLOYMENT COMPENSATION XIX D	83,663
	WORKERS COMPENSATION INSURANC XIX D	161,206
	HOSPITALIZATION INSURANCE XIX D	192,812
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	59,999
	CHICAGO HEAD TAX XIX D	0
		0
		929,778
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	1,987
	TRAVEL XIX G	0
		1,987
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	15,334
		15,334
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	170,184
		170,184
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	407,512
		407,512

GRAND TOTAL COLUMN 3 OTHER

2,124,758

**BURNHAM HEALTHCARE  
SCHEDULES  
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	437,942
LESS SALES TAX	<u>(2,204)</u>
NET FOOD	435,738

TOTAL PATIENT CENSUS	110,814
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	332,442

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	332,442
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	332,442

NET FOOD	435,738
DIVIDE TOTAL MEALS/YEAR	<u>332,442</u>

COST PER MEAL	1.31
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			20,801	20,801		20,801	504,356	525,157		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			7,222	7,222		7,222	786,351	793,573		32
33	Real Estate Taxes							645,112	645,112		33
34	Rent-Facility & Grounds			1,926,000	1,926,000		1,926,000	(1,926,000)			34
35	Rent-Equipment & Vehicles			47,269	47,269		47,269	6,160	53,429		35
36	Other (specify):* <b>IME</b>			24,102	24,102		24,102	53,016	77,118		36
37	<b>TOTAL Ownership</b>			2,025,394	2,025,394		2,025,394	68,995	2,094,389		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		187,006	263,624	450,630		450,630		450,630		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	<b>TOTAL Special Cost Centers</b>		187,006	432,802	619,808		619,808		619,808		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,753,257	1,090,827	4,582,954	11,427,038		11,427,038	(218,570)	11,208,468		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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	150,288	30		9
10	Interest and Other Investment Income	(39,820)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,204)	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		21		18
19	Entertainment		20		19
20	Contributions	(3,939)	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	(407,512)	27		24
25	Fund Raising, Advertising and Promotional	(2,434)	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	(24,312)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (329,933)		\$	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	111,363		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 111,363		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (218,570)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BURNHAM HEALTHCARE

ID# 0043398

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 2,338	6	1
2	MARKETING SALARIES	(24,066)	21	2
3	STAFF DEVELOPMENT	(1,407)	21	3
4	MARKETING AUTO LEASE	(1,177)	35	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(24,312)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	(2,204)	0	0	0	0	0	0	0	0	0	0	(2,204)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	2,519	0	0	0	0	0	0	0	0	2,519	4
5	Heat and Other Utilities	0	0	0	665	0	0	0	0	0	0	0	665	5
6	Maintenance	2,338	3,587	3,352	2,552	0	0	0	0	0	0	0	11,829	6
7	Other (specify):*	0	0	66	74	0	0	0	0	0	0	0	140	7
8	<b>TOTAL General Services</b>	<b>134</b>	<b>3,587</b>	<b>5,937</b>	<b>3,291</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>12,949</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	2,447	0	0	0	0	0	0	0	0	0	2,447	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>2,447</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,447</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(20,567)	16,087	0	0	0	0	0	0	0	0	(4,480)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,093	15,596	123	12,000	0	0	0	0	0	0	28,812	19
20	Fees, Subscriptions & Promotions	(6,373)	0	4,736	0	0	0	0	0	0	0	0	(1,637)	20
21	Clerical & General Office Expenses	(25,473)	18,789	34,475	107	0	0	0	0	0	0	0	27,898	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	85	0	0	0	0	0	0	0	0	85	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	790	1,016	0	0	0	0	0	0	0	0	1,806	25
26	Insurance-Prop.Liab.Malpractice	0	1,105	878	148	28,905	0	0	0	0	0	0	31,036	26
27	Other (specify):*	(407,512)	11,966	9,065	0	0	0	0	0	0	0	0	(386,481)	27
28	<b>TOTAL General Administration</b>	<b>(439,358)</b>	<b>13,176</b>	<b>81,938</b>	<b>378</b>	<b>40,905</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(302,961)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(439,224)</b>	<b>19,210</b>	<b>87,875</b>	<b>3,669</b>	<b>40,905</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(287,565)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	150,288	446	529	2,135	350,958	0	0	0	0	0	0	504,356	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(39,820)	0	0	4,017	822,154	0	0	0	0	0	0	786,351	32
33	Real Estate Taxes	0	0	0	2,991	642,121	0	0	0	0	0	0	645,112	33
34	Rent-Facility & Grounds	0	0	0	0	(1,926,000)	0	0	0	0	0	0	(1,926,000)	34
35	Rent-Equipment & Vehicles	(1,177)	1,793	4,833	711	0	0	0	0	0	0	0	6,160	35
36	Other (specify):*	0	0	0	(24,102)	77,118	0	0	0	0	0	0	53,016	36
37	<b>TOTAL Ownership</b>	<b>109,291</b>	<b>2,239</b>	<b>5,362</b>	<b>(14,248)</b>	<b>(33,649)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>68,995</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(329,933)</b>	<b>21,449</b>	<b>93,237</b>	<b>(10,579)</b>	<b>7,256</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(218,570)</b>	<b>45</b>

**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
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		IME REALTY CORP	LINCOLNWOOD	HOME OFFICE
				BURNHAM		
				HELATHCARE		
				REALTY	LINCOLNWOOD	LANDLORD

**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	\$ 44,500	EMI ENTERPRISE		\$	(44,500)	1	
2	V	6 DRIVER'S SALARY				3,587	3,587	2	
3	V	10 NURSING CONSULTANTS				2,447	2,447	3	
4	V	17 OFFICER'S SALARY-M.E.				23,933	23,933	4	
5	V	19 ACCOUNTING FEES				1,093	1,093	5	
6	V	21 OFFICE EXPENSE				18,789	18,789	6	
7	V	25 TRANSPORTATION				790	790	7	
8	V	26 INSURANCE				1,105	1,105	8	
9	V	27 EMPLOYEE BENEFITS				11,966	11,966	9	
10	V	30 DEPRECIATION				446	446	10	
11	V	35 AUTO LEASE				1,793	1,793	11	
12	V							12	
13	V							13	
14	Total		\$ 44,500			\$ 65,949	\$ *	21,449	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	\$ 11,000	EKS MANAGEMENT		\$	\$(11,000)
16	V	4 HOUSEKEEPING SALARIES				2,519	2,519
17	V	6 PAINTERS' SALARIES				3,352	3,352
18	V	7 SCAVENGER				66	66
19	V	17 CFO SALARY - A. WEINFELD				16,087	16,087
20	V	19 PROFESSIONAL FEES				15,596	15,596
21	V	20 WANT ADS / BACKGR CKS				4,736	4,736
22	V	21 OFFICE EXPENSE				45,475	45,475
23	V	23 SEMINARS				85	85
24	V	25 TRANSPORTATION				1,016	1,016
25	V	26 INSURANCE				878	878
26	V	27 EMPLOYEE BENEFITS				9,065	9,065
27	V	30 DEPRECIATION S.L				529	529
28	V	35 EQUIPMENT RENT				4,833	4,833
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 11,000			\$ 104,237	\$ * 93,237

\* 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		\$ 665	\$ (24,102)
16	V	5 UTILITIES				665	665
17	V	6 PAINTERS FEES				793	793
18	V	6 REPAIRS / MAINT				1,759	1,759
19	V	7 ALARM SERVICE				74	74
20	V	19 PROFESSIONAL FEES				123	123
21	V	21 OFFICE EXPENSE				107	107
22	V	26 INSURANCE				148	148
23	V	30 DEPRECIATION S/L				2,135	2,135
24	V	32 INTEREST				4,017	4,017
25	V	33 R/E TAX				2,991	2,991
26	V	35 STORAGE FEES				711	711
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			\$ 13,523	\$ * (10,579)

\* 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	\$ 1,926,000	BURNHAM HEALTH CARE REALTY		\$	(1,926,000)	15
16	V	19 PROFESSIONAL FEES				12,000	12,000	16
17	V	26 INSURANCE				28,905	28,905	17
18	V	30 DEPR. S.L. BUILDING				350,958	350,958	18
19	V	32 INTEREST				822,154	822,154	19
20	V	33 REAL ESTATE TAXES				642,121	642,121	20
21	V	36 M.I.P. INSURANCE				77,118	77,118	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,926,000			\$ 1,933,256	\$ * 7,256	39

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

Facility Name &amp; ID Number

BURNHAM HEALTHCARE

#

0043398

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	38.00		SEE		SALARY	\$ 23,933	17-7	1
2						ATTACHED		FR EMI			2
3						SCHEDULE					3
4	PHILIP ESFORMES	MEMBER	MANAGEMENT	19.00				MNGT FEE	44,500	17-3	4
5											5
6											6
7	AVRUM WEINFELD	CFO	FIN. OFFICER					salary fr eks	16,087	17-7	7
8	FLORA WEISS		CLERICAL			ATTACHED		Comp fr EKS	2,161	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 86,681		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:

**01/01/2007**

Ending: **2/31/2007**

**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	6	DRIVER'S SALARY	PATIENT DAYS	342,637	4	\$ 11,091	\$ 110,814	\$ 3,587	1	
2	10	NURSING CONSULTANTS	PATIENT DAYS	342,637	4	7,567	110,814	2,447	2	
3	17	OFFICER'S SALARY-M.E.	PATIENT DAYS	342,637	4	74,000	110,814	23,933	3	
4	19	ACCOUNTING FEES	PATIENT DAYS	342,637	4	3,380	110,814	1,093	4	
5	21	OFFICE EXPENSE	PATIENT DAYS	342,637	4	58,095	43,765	110,814	18,789	5
6	25	TRANSPORTATION	PATIENT DAYS	342,637	4	2,444	110,814	790	6	
7	26	INSURANCE	PATIENT DAYS	342,637	4	3,417	110,814	1,105	7	
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	342,637	4	37,000	110,814	11,966	8	
9	30	DEPRECIATION	PATIENT DAYS	342,637	4	1,380	110,814	446	9	
10	35	AUTO LEASE	PATIENT DAYS	342,637	4	5,543	110,814	1,793	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					\$ 203,917	\$ 43,765	\$ 65,949	25	

Facility Name & ID Number **BURNHAM HEALTHCARE**

# **0043398**

Report Period Beginning:

**01/01/2007**

Ending: **2/31/2007**

**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	857,979	14	\$ 19,500	\$ 110,814	\$ 2,519	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	857,979	14	25,953	110,814	3,352	2
3	7	SCAVENGER	PATIENT DAYS	857,979	14	512	110,814	66	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	857,979	14	124,552	110,814	16,087	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	857,979	14	120,756	110,814	15,596	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	857,979	14	36,665	110,814	4,736	6
7	21	OFFICE EXPENSE	PATIENT DAYS	857,979	14	352,089	110,814	45,475	7
8	23	SEMINARS	PATIENT DAYS	857,979	14	659	110,814	85	8
9	25	TRANSPORTATION	PATIENT DAYS	857,979	14	7,865	110,814	1,016	9
10	26	INSURANCE	PATIENT DAYS	857,979	14	6,798	110,814	878	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	857,979	14	70,186	110,814	9,065	11
12	30	DEPRECIATION S.L	PATIENT DAYS	857,979	14	4,096	110,814	529	12
13	35	EQUIPMENT RENT	PATIENT DAYS	857,979	14	37,419	110,814	4,833	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					\$ 807,050	\$ 416,692	\$ 104,237	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

# **0043398** Report Period Beginning: **01/01/2007** Ending: **2/31/2007**

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

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	5	UTILITIES	INCOME	187,059	15	\$ 5,162	\$ 24,102	\$ 665	1
2	6	PAINTERS FEES	INCOME	187,059	15	6,152	24,102	793	2
3	6	REPAIRS/MAINT	INCOME	187,059	15	13,651	24,102	1,759	3
4	7	ALARM SERVICE	INCOME	187,059	15	575	24,102	74	4
5	19	PROFESSIONAL FEES	INCOME	187,059	15	952	24,102	123	5
6	21	OFFICE EXPENSE	INCOME	187,059	15	831	24,102	107	6
7	26	INSURANCE	INCOME	187,059	15	1,150	24,102	148	7
8	30	DEPRECIATION	INCOME	187,059	15	16,570	24,102	2,135	8
9	32	INTEREST	INCOME	187,059	15	31,178	24,102	4,017	9
10	33	R/E TAX	INCOME	187,059	15	23,213	24,102	2,991	10
11	35	STORAGE FEES	INCOME	187,059	15	5,519	24,102	711	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					\$ 104,953	\$	\$ 13,523	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

# **0043398** Report Period Beginning: **01/01/2007** Ending: **2/31/2007**

**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  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847 ) 674-5795  
 Fax Number ( 847 ) 675-5794

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	19	PROFESSIONAL FEES	DIRECT COST	1	1	\$ 12,000	\$ 1	\$ 12,000	1
2	26	INSURANCE	DIRECT COST	1	1	28,905	1	28,905	2
3	30	DEPR. S.L. BUILDING	DIRECT COST	1	1	350,958	1	350,958	3
4	32	INTEREST	DIRECT COST	1	1	822,154	1	822,154	4
5	33	REAL ESTATE TAXES	DIRECT COST	1	1	642,121	1	642,121	5
6	36	M.I.P. INSURANCE	DIRECT COST	1	1	77,118	1	77,118	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					\$ 1,933,256	\$	\$ 1,933,256	25

Facility Name & ID Number

**BURNHAM HEALTHCARE**

# **0043398**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007**

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	<b>CAMBRIDGE REALTY</b>		<b>X</b>	<b>MORTGAGE</b>	<b>\$85,698.11</b>	<b>11/21/03</b>	<b>\$ 16,088,500</b>	<b>\$ 15,328,685</b>	<b>9/1/37</b>	<b>0.0533</b>	<b>\$ 822,154</b>	<b>1</b>								
2												<b>2</b>								
3												<b>3</b>								
4												<b>4</b>								
5												<b>5</b>								
<b>Working Capital</b>																				
6	<b>LASALLE BANK</b>		<b>X</b>	<b>WORKING CAPITAL</b>	<b>INT ONLY</b>						<b>7,222</b>	<b>6</b>								
7	<b>IME-RELATED PARTY</b>										<b>4,017</b>	<b>7</b>								
8												<b>8</b>								
9	<b>TOTAL Facility Related</b>				<b>\$85,698.11</b>		<b>\$ 16,088,500</b>	<b>\$ 15,328,685</b>			<b>\$ 833,393</b>	<b>9</b>								
<b>B. Non-Facility Related*</b>																				
10	<b>IRS, IDR, ETC</b>		<b>X</b>	<b>LATE FEES</b>								<b>10</b>								
11												<b>11</b>								
12												<b>12</b>								
13												<b>13</b>								
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	<b>14</b>								
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 16,088,500</b>	<b>\$ 15,328,685</b>			<b>\$ 833,393</b>	<b>15</b>								

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 2006 report.		\$	<b>631,207</b>	<b>1</b>
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.)		\$	<b>628,952</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(2,255)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>644,376</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>642,121</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>651,239</b>	<b>8</b>
	2003	<b>689,451</b>	<b>9</b>
	2004	<b>720,502</b>	<b>10</b>
	2005	<b>613,021</b>	<b>11</b>
	2006	<b>628,952</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED**

**ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.**

**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:** 2006 REAL ESTATE TAX COST DOCUMENTATION

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

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

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

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

FACILITY NAME 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 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>30-06-313-040-000</u>	<u>NURSING HOME</u>	\$ <u>509,313.69</u>	\$ <u>509,313.69</u>
2. <u>30-06-313-045-000</u>	<u>NURSING HOME</u>	\$ <u>3,387.57</u>	\$ <u>3,387.57</u>
3. <u>30-06-313-051-000</u>	<u>NURSING HOME</u>	\$ <u>24,947.30</u>	\$ <u>24,947.30</u>
4. <u>30-06-313-052-000</u>	<u>NURSING HOME</u>	\$ <u>6,536.10</u>	\$ <u>6,536.10</u>
5. <u>30-06-313-053-000</u>	<u>NURSING HOME</u>	\$ <u>8,351.42</u>	\$ <u>8,351.42</u>
6. <u>30-06-313-054-000</u>	<u>NURSING HOME</u>	\$ <u>76,415.72</u>	\$ <u>76,415.72</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>628,951.80</u>	\$ <u>628,951.80</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number BURNHAM HEALTHCARE

# 0043398

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			<u>1998</u>	<u>\$ 1,500,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 1,500,000</b>	<b>3</b>

Facility Name &amp; ID Number BURNHAM HEALTHCARE

# 0043398

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	309	1998		\$ 12,649,700	\$ 324,351	39	\$ 324,351	\$	\$ 3,166,532	4
5										5
6										6
7	RELATED PARTY			71,100	2,051		2,051			7
8	OFFICE									8
	Improvement Type**									
9	ROOF - REALTY		1998	74,000	1,897	39	1,897		17,733	9
10	WALLCOVERINGS - REALTY		1998	39,379	1,010	39	1,010		9,437	10
11	PAINTING - REALTY		1998	12,962	332	39	332		3,106	11
12	WINDOW TREATMENTS - REALTY		1998	38,112	977	39	977		9,133	12
13	FENCE - REALTY		1998	650	17	39	17		156	13
14	NEW WINDOWS - REALTY		1998	20,445	524	39	524		4,899	14
15	PAINTERS SALARIES - REALTY		1998	64,064	1,643	39	1,643		15,353	15
16	NURSE STATION - REALTY		1998	23,100	592	39	592		5,535	16
17	TILING - REALTY		1998	635	17	39	17		153	17
18	BUILT IN CABINETS - REALTY		1998	64,700	1,659	39	1,659		15,505	18
19	NEW COILS FOR AHV - REALTY		1999	6,000	154	39	154		1,311	19
20	NEW BOILER - REALTY		1999	20,328	521	39	521		4,435	20
21	HOT WATER TANK - REALTY		1999	2,750	71	39	71		604	21
22	ROOF - REALTY		1999	29,500	756	39	756		6,435	22
23	PATIO - REALTY		1999	5,080	339	15	339		2,884	23
24	AWNING - REALTY		1999	3,000	200	15	200		1,703	24
25	LIGHTS - REALTY		1999	7,603	195	39	195		1,660	25
26	NURSE CALL STATION - REALTY		1999	1,957	50	39	50		426	26
27	WINDOW TREATMENTS - REALTY		1999	11,207	287	39	287		2,444	27
28	CORRIDOR BORDERS - REALTY		1999	6,154	158	39	158		1,345	28
29	SCREENS - REALTY		2000	3,543	129	27.5	129		970	29
30	AIR CONDITIONER REPLACEMENT - REALTY		2001	14,540	529	27.5	529		3,444	30
31	DOOR DETECTOR - REALTY		2001	1,800	65	27.5	65		424	31
32	A/C COMPRESSOR & REBUILT AIR HANDLER - REALTY		2001	22,621	823	27.5	823		5,360	32
33	ROOF VENTILATORS - REALTY		2001	6,898	251	27.5	251		1,635	33
34	BOILER - REALTY		2001	63,746	2,318	27.5	2,318		15,096	34
35	WALK IN FREEZER - REALTY		2001	3,750	136	27.5	136		886	35
36	DOOR - REALTY		2001	2,970	108	27.5	108		703	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number BURNHAM HEALTHCARE

# 0043398

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## 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	\$	\$ 958	37
38	DOORS - REALTY	2001	1,995	72	27.5	72		469	38
39	DOORS - REALTY	2001	1,723	63	27.5	63		410	39
40	FLOOR TILING & CARPETING	2001	4,497		5			4,497	40
41	DRAPERIES	2001	12,722		5			12,722	41
42	HOT WATER HEATER & PIPING - REALTY	2002	19,857	722	27.5	722		3,980	42
43	ROOF - REALTY	2002	6,150	224	27.5	224		1,234	43
44	ELECTRIC DOOR LOCKING SYSTEM - REALTY	2002	2,326	84	27.5	84		464	44
45	DOORS - REALTY	2002	10,098	367	27.5	367		2,023	45
46	TILING - REALTY	2002	17,815	648	27.5	648		3,572	46
47	SAFETY LOCK SYSTEM - REALTY	2002	5,854	213	27.5	213		1,174	47
48	ELEVATOR REPAIR - REALTY	2002	39,650	1,442	27.5	1,442		7,949	48
49	BOILER - REALTY	2002	9,550	347	27.5	347		1,913	49
50	ELEVATOR - REALTY	2003	100,632	3,659	27.5	3,659		16,700	50
51	PATIO DOORS - REALTY	2003	2,300	84	27.5	84		383	51
52	FLOORING IN ELEVATORS - REALTY	2003	1,155	42	27.5	42		191	52
53	NURSES STATION - REALTY	2003	6,806	247	27.5	247		1,128	53
54	KITCHEN CABINETS - REALTY	2003	2,836	103	27.5	103		471	54
55	KITCHEN FLOORING - REALTY	2003	2,673	97	27.5	97		443	55
56	PATIO TILING & LIGHTING - REALTY	2003	4,688	170	27.5	170		776	56
57	COVE BASE IN ANNEX CORRIDOR - REALTY	2003	824	30	27.5	30		136	57
58	HANDRAILS & BUMPER GUARDS - REALTY	2003	8,565	311	27.5	311		1,420	58
59	LIGHTING FOR CORRIDORS - REALTY	2003	1,410	51	27.5	51		233	59
60	KICKPLATES - REALTY	2003	5,300	193	27.5	193		880	60
61	FREIGHT & SALES TAX ON ABOVE IMP. - REALTY	2003	816	30	27.5	30		136	61
62	DOOR ALARM SYSTEM	2004	3,076	112	27.5	112		397	62
63	NEW FLOORING	2004	39,141	1,423	27.5	1,423		5,040	63
64	AIR CONDITIONING CHILLER UNIT	2004	14,876	541	27.5	541		1,916	64
65	TILE FLOORING	2004	4,031	147	27.5	147		520	65
66	FIRE SUPPRESSION SYSTEMS	2004	5,001	182	27.5	182		644	66
67	SHOWER, BATH & TUB ROOMS AND KITCHEN	2004	72,837	2,649	27.5	2,649		9,382	67
68	AIR CONDITIONING UNIT	2004	5,484	199	27.5	199		705	68
69	POWER ROOF EXHAUST UNITS	2005	3,972	145	27.5	145		320	69
70	TOTAL (lines 4 thru 69)		\$ 13,695,004	\$ 356,904		\$ 356,904	\$	\$ 3,382,493	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 13,695,004	\$ 356,904		\$ 356,904	\$	\$ 3,382,493	1
2	RECLAIM PUMPS	2005	1,770	64	27.5	64		142	2
3	POWER ROOF EXHAUST FANS	2005	3,545	129	27.5	129		285	3
4	GREASE BASIN	2005	11,800	429	27.5	429		947	4
5	CUBICAL CURTAINS	2005	3,784	727	5	757	30	1,892	5
6	WALL MOUNTED WATER COOLER	2006	1,808	66	27.5	66		90	6
7	FIRE SUPPRESSION SYSTEM	2006	5,200	189	27.5	189		261	7
8	DOORS	2006	2,150	78	27.5	78		153	8
9	CARPETING	2006	2,690	861	5	538	(323)	857	9
10	ROOF REPAIR - REALTY	2007	4,900	7	27.5	7		7	10
11	BUILDING IMPROVEMENT- REALTY	2006	41,151	1,496	27.5	1,496		1,995	11
12	BUILDING IMPROVEMENT	2007	(41,151)	(1,434)	27.5	(1,434)		(1,434)	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,732,651	\$ 359,516		\$ 359,223	\$ (293)	\$ 3,387,688	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	\$ 1,646,368	\$ 12,917	\$ 164,531	\$ 151,614	10 YRS	\$ 1,448,628	71
72	Current Year Purchases	6,884	1,377	344	(1,033)	10 YRS	344	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY</b>		1,059	1,059				74
75	<b>TOTALS</b>	\$ 1,653,252	\$ 15,353	\$ 165,934	\$ 150,581		\$ 1,448,972	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 16,885,903	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 374,869	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 525,157	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 150,288	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,836,660	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	<b>TOTALS</b>	\$	\$	\$	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		\$ 1,926,000			3
4	Additions							4
5								5
6								6
7	TOTAL		309		\$ 1,926,000			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: \$ 12,671 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			\$	\$ 34,598	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 34,598	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. \_\_\_\_\_/2008 \$ \_\_\_\_\_

13. \_\_\_\_\_/2009 \$ \_\_\_\_\_

14. \_\_\_\_\_/2010 \$ \_\_\_\_\_

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

**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	\$		\$ 119,656	\$		\$ 119,656	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			291			291	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			143,677			143,677	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				166,488		166,488	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>supplies, lab, misc</b>	39-8					20,518		20,518	13
14	<b>TOTAL</b>			\$		\$ 263,624	\$ 187,006		\$ 450,630	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 &amp; ID Number BURNHAM HEALTHCARE

# 0043398

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 92,093	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (500,000) )	1,532,341		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	199,144		6
7	Other Prepaid Expenses	1,118		7
8	Accounts Receivable (owners or related parties)	53,195		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,877,891	\$	10
	<b>B. Long-Term Assets</b>			
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	157,233		15
16	Equipment, at Historical Cost	1,653,252		16
17	Accumulated Depreciation (book methods)	(1,680,098)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 130,387	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,008,278	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,053,938	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	115,000		29
30	Accrued Salaries Payable	198,461		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,628		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>DUE TO RELATED PARTIES</b>	234,530		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,630,557	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,630,557	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 377,721	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,008,278	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):	<b>829,100</b>	<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>POST CLOSING DENTRIES</b>	<b>(14,750)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>814,350</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>496,471</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(933,100)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(436,629)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>377,721</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 11,718,442	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,718,442	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	165,247	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 165,247	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	39,820	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 39,820	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,923,509	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,188,546	31
32	Health Care	4,461,126	32
33	General Administration	2,132,164	33
	<b>B. Capital Expense</b>		
34	Ownership	2,025,394	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	450,630	35
36	Provider Participation Fee	169,178	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,427,038	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	496,471	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 496,471	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: 01/01/2007

Ending: 12/31/2007

**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	4,231	4,481	\$ 147,273	\$ 32.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,427	21,890	592,442	27.06	3
4	Licensed Practical Nurses	51,139	53,786	1,206,709	22.44	4
5	CNAs & Orderlies	132,000	143,756	1,456,992	10.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,561	9,585	135,185	14.10	8
9	Activity Director					9
10	Activity Assistants	17,056	18,302	165,180	9.03	10
11	Social Service Workers	16,612	18,380	243,159	13.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,493	40,860	392,028	9.59	15
16	Dishwashers					16
17	Maintenance Workers	7,128	7,495	91,478	12.21	17
18	Housekeepers	38,166	41,350	404,055	9.77	18
19	Laundry	13,257	14,543	126,380	8.69	19
20	Administrator	2,086	2,284	130,357	57.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,086	2,086	24,066	11.54	23
24	Clerical	11,045	12,265	147,481	12.02	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	2,086	2,362	25,029	10.60	31
32	Other Health Care(specify)	13,913	15,097	221,376	14.66	32
33	Other(specify)	22,852	24,755	244,067	9.86	33
34	TOTAL (lines 1 - 33)	400,138	433,277	\$ 5,753,257 *	\$ 13.28	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	M	\$ 15,660	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,099	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	29	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	100	10a-3	43
44	Activity Consultant	E	392	11-3	44
45	Social Service Consultant	E	4,046	12-3	45
46	Other(specify) <u>Physicians</u>	S	6,000	10-3	46
47	<u>Dental Consultant</u>		3,985	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,311		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	Certified Nurse Assistants/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	
FRED BERKOVITS	ADMINISTRATOR		\$ 130,357	Workers' Compensation Insurance	\$ 161,206	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	83,663	Advertising: Employee Recruitment	1,223	
	OTHER ADMIN		0	FICA Taxes	432,098	Health Care Worker Background Check	0	
				Employee Health Insurance	192,812	(Indicate # of checks performed )		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	3,939	
				EMPLOYEE BENEFITS - OTHER	0	MARKETING/ADV/PROMO	2,434	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	16,980	
				PENSION/PROFIT SHARING PLANS	59,999	MGMT CO ALLOC	4,736	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(3,939)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(2,434)	
						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)	\$ 929,778	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,939	
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, MANAGEMENT FEE			\$ 44,500			\$	Out-of-State Travel	\$
PHILLIP ESFORMES, INC, MANAGEMENT FEE			44,500					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 89,000				Seminar Expense	1,987
C. Professional Services							Entertainment Expense	( )
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$				TOTAL	\$ 1,987
SEE SCHEDULE ATTACHED			53,472					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 53,472	TOTAL		\$		

\* 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	Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011	14 FY2012
1	PAINT/DECORATING	2004	\$ 3,092	3 YRS	\$ 515	\$ 1,031	\$ 1,031	\$ 515	\$	\$	\$	\$	\$
2	PAINT/DECORATING	2005	2,333	3 YRS		379	788	788	378				
3	PAINT/DECORATING	2006	3,105	3 YRS			518	1,035	1,035	517			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$ 8,530		\$ 515	\$ 1,410	\$ 2,337	\$ 2,338	\$ 1,413	\$ 517	\$	\$	\$

Facility Name &amp; ID Number BURNHAM HEALTHCARE

# 0043398

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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 \$12,747
- (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. \$ 3,559 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 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. \$ 0 Has any meal income been offset against related costs? N/A 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 \$5,000, 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