

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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

<p>I. IDPH License ID Number: <u>0043398</u></p> <p>Facility Name: <u>BURNHAM HEALTHCARE</u></p> <p>Address: <u>14500 SOUTH MANISTEE</u> <u>BURNHAM</u> <u>60633</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u></p> <p>HFS ID Number: <u>36-4205217</u></p> <p>Date of Initial License for Current Owners: <u>03/01/98</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MORRIS ESFORMES</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>MORRIS ESFORMES</u>			(Title) <u>MEMBER</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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<p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>																																									

Facility Name & ID Number BURNHAM HEALTHCARE

0043398 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	37,698	1
2		Skilled Pediatric (SNF/PED)			2
3	206	Intermediate (ICF)	206	75,396	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	309	TOTALS	309	113,094	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	19,432	119	6,006	25,557	8
9	SNF/PED					9
10	ICF	84,573	1,132	315	86,020	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	104,005	1,251	6,321	111,577	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.66%

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 6,006

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **BURNHAM HEALTHCARE** # **0043398** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	398,775	54,111	16,533	469,419		469,419		469,419		1
2	Food Purchase		478,362		478,362		478,362	(2,499)	475,863		2
3	Housekeeping	404,830	64,836		469,666		469,666		469,666		3
4	Laundry	132,712	29,910	15,254	177,876		177,876	2,532	180,408		4
5	Heat and Other Utilities			267,965	267,965		267,965	720	268,685		5
6	Maintenance	91,910	57,520	65,933	215,363		215,363	12,862	228,225		6
7	Other (specify):* Security	188,037		22,814	210,851		210,851	151	211,002		7
8	TOTAL General Services	1,216,264	684,739	388,499	2,289,502		2,289,502	13,766	2,303,268		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	3,769,421	136,939	28,228	3,934,588		3,934,588		3,934,588		10
10a	Therapy	130,975	4,057	22,150	157,182		157,182		157,182		10a
11	Activities	161,796	53,271	2,736	217,803		217,803		217,803		11
12	Social Services	306,941		2,594	309,535		309,535		309,535		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,369,133	194,267	61,708	4,625,108		4,625,108		4,625,108		16
	C. General Administration										
17	Administrative	130,714		45,000	175,714		175,714	27,715	203,429		17
18	Directors Fees										18
19	Professional Services			59,157	59,157		59,157	28,160	87,317		19
20	Dues, Fees, Subscriptions & Promotions			34,303	34,303		34,303	(11,983)	22,320		20
21	Clerical & General Office Expenses	225,540	45,267	42,921	313,728		313,728	23,620	337,348		21
22	Employee Benefits & Payroll Taxes			893,800	893,800		893,800		893,800		22
23	Inservice Training & Education							12	12		23
24	Travel and Seminar			4,304	4,304		4,304		4,304		24
25	Other Admin. Staff Transportation			22,205	22,205		22,205	1,813	24,018		25
26	Insurance-Prop.Liab.Malpractice			165,553	165,553		165,553	30,041	195,594		26
27	Other (specify):*			871,415	871,415		871,415	(847,452)	23,963		27
28	TOTAL General Administration	356,254	45,267	2,138,658	2,540,179		2,540,179	(748,074)	1,792,105		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,941,651	924,273	2,588,865	9,454,789		9,454,789	(734,308)	8,720,481		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	16,533
	REPAIRS & MAINTENANCE	0
		0
		16,533
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	15,254
		0
		15,254
5	HEAT & OTHER UTILITIES	
	GAS HEAT	102,453
	ELECTRICITY	112,400
	WATER	49,065
	CABLE TV - LOBBY	4,047
		0
		267,965
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,568
	PAINTING & DECORATING	2,945
	BUILDING REPAIRS	3,504
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	27,436
	ELEVATOR MAINTENANCE & REPAIR	11,923
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	6,372
	FIRE SERVICE	7,185
		0
		0
		0
		0
		65,933
7	OTHER	
	SCAVENGER	21,604
	SECURITY SERVICE	1,210
		0
		0
		22,814
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	3,863
	PHARMACY CONSULTANT XVIII B 39-2	1,440
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	6,000
	PSYCHIATRIC XVIII B ___-2	0
	PROGRAM CONSULTANT XVIII B 38-2	4,332
	NURSING PROGRAM CONSULTANT	8,693
	DENTAL	3,900
		28,228
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	22,150
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		22,150
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,736
		0
		2,736
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	2,594
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,594
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	45,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	25,584
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	33,573
		0
		59,157
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,002
	EMPLOYEE WANT ADS XIX F	775
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	10,933
	LICENSES & PERMITS XIX F	6,542
	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	12,551
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		34,303
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,480
	EQUIPMENT REPAIR & MAINTENANCE	5,371
	OUTSIDE CLERICAL SERVICES	12,000
	PENALTIES / OVERDRAFT CHARGES VI 18	1,333
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	19,737
	MESSENGER SERVICE	0
		0
		42,921

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	446,172
	UNEMPLOYMENT COMPENSATION XIX D	68,983
	WORKERS COMPENSATION INSURANC XIX D	112,238
	HOSPITALIZATION INSURANCE XIX D	207,955
	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	58,452
	CHICAGO HEAD TAX XIX D	0
		0
		893,800
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	4,304
	TRAVEL XIX G	0
		4,304
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	22,205
		22,205
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	165,553
		165,553
27	OTHER	
	BAD DEBTS VI 24	871,415
		871,415

GRAND TOTAL COLUMN 3 OTHER

2,588,865

**BURNHAM HEALTHCARE
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	478,362
LESS SALES TAX	<u>(2,499)</u>
NET FOOD	475,863

TOTAL PATIENT CENSUS	111,577
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	334,731

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	334,731
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	334,731

NET FOOD	475,863
DIVIDE TOTAL MEALS/YEAR	<u>334,731</u>

COST PER MEAL	1.42
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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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			44,742	44,742		44,742	424,405	469,147		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			39,447	39,447		39,447	797,473	836,920		32
33	Real Estate Taxes							691,567	691,567		33
34	Rent-Facility & Grounds			2,016,000	2,016,000		2,016,000	(2,016,000)			34
35	Rent-Equipment & Vehicles			55,749	55,749		55,749	4,684	60,433		35
36	Other (specify):* IME			24,102	24,102		24,102	51,959	76,061		36
37	TOTAL Ownership			2,180,040	2,180,040		2,180,040	(45,912)	2,134,128		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		185,856	245,578	431,434		431,434		431,434		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			169,642	169,642		169,642		169,642		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		185,856	415,220	601,076		601,076		601,076		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,941,651	1,110,129	5,184,125	12,235,905		12,235,905	(780,220)	11,455,685		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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	67,775	30		9
10	Interest and Other Investment Income	(14,797)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,499)	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	(1,333)	21		18
19	Entertainment		20		19
20	Contributions	(13,051)	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	(871,415)	27		24
25	Fund Raising, Advertising and Promotional	(3,002)	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	(26,465)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (864,787)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	84,567		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 84,567		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (780,220)		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						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: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,413	6	1
2	MARKETING SALARIES	(24,132)	21	2
3	MARKETING AUTO LEASING	(1,177)	35	3
4	INTEREST INCOME ON BURNAM REALTY	(2,569)	32	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	(26,465)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(2,499)	0	0	0	0	0	0	0	0	0	0	(2,499)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	2,532	0	0	0	0	0	0	0	0	2,532	4
5	Heat and Other Utilities	0	0	0	720	0	0	0	0	0	0	0	720	5
6	Maintenance	1,413	4,862	3,369	3,218	0	0	0	0	0	0	0	12,862	6
7	Other (specify):*	0	0	112	39	0	0	0	0	0	0	0	151	7
8	TOTAL General Services	(1,086)	4,862	6,013	3,977	0	0	0	0	0	0	0	13,766	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	11,674	16,041	0	0	0	0	0	0	0	0	27,715	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	504	15,381	275	12,000	0	0	0	0	0	0	28,160	19
20	Fees, Subscriptions & Promotions	(16,053)	0	4,070	0	0	0	0	0	0	0	0	(11,983)	20
21	Clerical & General Office Expenses	(25,465)	12,994	36,028	63	0	0	0	0	0	0	0	23,620	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	12	0	0	0	0	0	0	0	0	12	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	761	1,052	0	0	0	0	0	0	0	0	1,813	25
26	Insurance-Prop.Liab.Malpractice	0	1,001	790	164	28,086	0	0	0	0	0	0	30,041	26
27	Other (specify):*	(871,415)	13,990	9,973	0	0	0	0	0	0	0	0	(847,452)	27
28	TOTAL General Administration	(912,933)	40,924	83,347	502	40,086	0	0	0	0	0	0	(748,074)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(914,019)	45,786	89,360	4,479	40,086	0	0	0	0	0	0	(734,308)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	67,775	174	382	2,234	353,840	0	0	0	0	0	0	424,405	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,366)	0	0	4,101	810,738	0	0	0	0	0	0	797,473	32
33	Real Estate Taxes	0	0	0	3,114	688,453	0	0	0	0	0	0	691,567	33
34	Rent-Facility & Grounds	0	0	0	0	(2,016,000)	0	0	0	0	0	0	(2,016,000)	34
35	Rent-Equipment & Vehicles	(1,177)	904	4,199	758	0	0	0	0	0	0	0	4,684	35
36	Other (specify):*	0	0	0	(24,102)	76,061	0	0	0	0	0	0	51,959	36
37	TOTAL Ownership	49,232	1,078	4,581	(13,895)	(86,908)	0	0	0	0	0	0	(45,912)	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)	(864,787)	46,864	93,941	(9,416)	(46,822)	0	0	0	0	0	0	(780,220)	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
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EMI ENTERPRISE	LINCOLNWOOD	CONSULTING
				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	\$ 25,000	EMI ENTERPRISE		\$	(25,000)	1	
2	V	6				4,862	4,862	2	
3	V	17				25,315	25,315	3	
4	V	17				11,359	11,359	4	
5	V	19				504	504	5	
6	V	21				12,994	12,994	6	
7	V	25				761	761	7	
8	V	26				1,001	1,001	8	
9	V	27				13,990	13,990	9	
10	V	30				174	174	10	
11	V	35				904	904	11	
12	V							12	
13	V							13	
14	Total		\$ 25,000			\$ 71,864	\$ *	46,864	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	\$ 12,000	EKS MANAGEMENT		\$	(12,000)
16	V	4 HOUSEKEEPING SALARIES				2,532	2,532
17	V	6 PAINTERS' SALARIES				3,369	3,369
18	V	7 SCAVENGER				112	112
19	V	17 CFO SALARY - A. WEINFELD				16,041	16,041
20	V	19 PROFESSIONAL FEES				15,381	15,381
21	V	20 WANT ADS / BACKGRD CKS				4,070	4,070
22	V	21 OFFICE EXPENSE				48,028	48,028
23	V	23 SEMINARS				12	12
24	V	25 TRANSPORTATION				1,052	1,052
25	V	26 INSURANCE				790	790
26	V	27 EMPLOYEE BENEFITS				9,973	9,973
27	V	30 DEPRECIATION S.L.				382	382
28	V	35 EQUIPMENT RENT				4,199	4,199
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 12,000			\$ 105,941	\$ * 93,941

* 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		\$ 720	\$ (24,102)
16	V	5 UTILITIES				720	720
17	V	6 PAINTERS FEES				1,585	1,585
18	V	6 REPAIRS / MAINT				1,633	1,633
19	V	7 ALARM SERVICE				39	39
20	V	19 PROFESSIONAL FEES				275	275
21	V	21 OFFICE EXPENSE				63	63
22	V	26 INSURANCE				164	164
23	V	30 DEPRECIATION S/L				2,234	2,234
24	V	32 INTEREST				4,101	4,101
25	V	33 R/E TAX				3,114	3,114
26	V	35 STORAGE FEES				758	758
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			\$ 14,686	\$ * (9,416)

* 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	\$ 2,016,000	BURNHAM HEALTH CARE REALTY		\$	(2,016,000)
16	V	19 PROFESSIONAL FEES				12,000	12,000
17	V	26 INSURANCE				28,086	28,086
18	V	30 DEPR. S.L. BUILDING & IMP				352,286	352,286
19	V	30 DEPR. S.L. EQUIP & FURN				1,554	1,554
20	V	32 INTEREST				810,738	810,738
21	V	33 REAL ESTATE TAXES				688,453	688,453
22	V	36 M.I.P. INSURANCE				76,061	76,061
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		\$ 2,016,000			\$ 1,969,178	\$ * (46,822)

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

Facility Name & ID Number

BURNHAM HEALTHCARE

#

0043398

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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				SALARY	\$ 25,315	17-7	1
2								FR EMI			2
3							SEE				3
4	PHILIP ESFORMES	MEMBER	MANAGEMENT	19.00			ATTACHED	MNGT FEE	20,000	17-3	4
5							SCHEDULES				5
6											6
7	AVRUM WEINFELD	CFO	FIN. OFFICER					salary fr eks	16,041	17-7	7
8	FLORA WEISS		CLERICAL					Comp fr EKS	2,171	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 63,527		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: **01/01/2008** Ending: **2/31/2008**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	6	DRIVERS' SALARY	PATIENT DAYS	859,462	14	\$ 37,451	\$ 37,451	111,577	\$ 4,862	1
2	17	OFFICER SALARY	PATIENT DAYS	859,462	14	195,000	195,000	111,577	25,315	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	859,462	14	87,500	87,500	111,577	11,359	3
4	19	ACCOUNTING FEES	PATIENT DAYS	859,462	14	3,885		111,577	504	4
5	21	OFFICE	PATIENT DAYS	859,462	14	100,089	57,703	111,577	12,994	5
6	25	TRANSPORTATION	PATIENT DAYS	859,462	14	5,861		111,577	761	6
7	26	INSURANCE	PATIENT DAYS	859,462	14	7,710		111,577	1,001	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	859,462	14	107,763		111,577	13,990	8
9	30	DEPRECIATION S/L	PATIENT DAYS	859,462	14	1,340		111,577	174	9
10	35	AUTO LEASE	PATIENT DAYS	859,462	14	6,960		111,577	904	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					\$ 553,559	\$ 377,654		\$ 71,864	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2008

Ending: **2/31/2008**

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 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

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	859,462	14	\$ 19,500	\$ 111,577	\$ 2,532	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	859,462	14	25,953	111,577	3,369	2
3	7	SCAVENGER	PATIENT DAYS	859,462	14	866	111,577	112	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	859,462	14	123,563	111,577	16,041	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	859,462	14	118,475	111,577	15,381	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	859,462	14	31,349	111,577	4,070	6
7	21	OFFICE EXPENSE	PATIENT DAYS	859,462	14	369,953	111,577	48,028	7
8	23	SEMINAR	PATIENT DAYS	859,462	14	95	111,577	12	8
9	25	TRANSPORTATION	PATIENT DAYS	859,462	14	8,106	111,577	1,052	9
10	26	INSURANCE	PATIENT DAYS	859,462	14	6,085	111,577	790	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	859,462	14	76,819	111,577	9,973	11
12	30	DEPRECIATION S.L	PATIENT DAYS	859,462	14	2,943	111,577	382	12
13	35	EQUIPMENT RENT	PATIENT DAYS	859,462	14	32,345	111,577	4,199	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					\$ 816,052	\$ 521,578	\$ 105,941	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2008

Ending: **2/31/2008**

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	187,059	15	\$ 5,588	\$ 24,102	\$ 720	1
2	6	PAINTERS FEES	INCOME	187,059	15	12,303	24,102	1,585	2
3	6	REPAIRS / MAINT	INCOME	187,059	15	12,671	24,102	1,633	3
4	7	ALARM SERVICE	INCOME	187,059	15	301	24,102	39	4
5	19	PROFESSIONAL FEES	INCOME	187,059	15	2,135	24,102	275	5
6	21	OFFICE EXPENSE	INCOME	187,059	15	489	24,102	63	6
7	26	INSURANCE	INCOME	187,059	15	1,275	24,102	164	7
8	30	DEPRECIATION	INCOME	187,059	15	17,336	24,102	2,234	8
9	32	INTEREST	INCOME	187,059	15	31,829	24,102	4,101	9
10	33	R/E TAX	INCOME	187,059	15	24,171	24,102	3,114	10
11	35	STORAGE FEES	INCOME	187,059	15	5,882	24,102	758	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					\$ 113,980	\$	\$ 14,686	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398 Report Period Beginning: **01/01/2008** Ending: **2/31/2008**

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	28,086	1	28,086	2
3	30	DEPR. S.L. BUILDING & IMP	DIRECT COST	1	1	352,286	1	352,286	3
4	30	DEPR. S.L. EQUIP & FURN	DIRECT COST	1	1	1,554	1	1,554	4
5	32	INTEREST	DIRECT COST	1	1	810,738	1	810,738	5
6	33	REAL ESTATE TAXES	DIRECT COST	1	1	688,453	1	688,453	6
7	36	M.I.P. INSURANCE	DIRECT COST	1	1	76,061	1	76,061	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					\$ 1,969,178	\$	\$ 1,969,178	25

Facility Name & ID Number

BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	\$ 810,738	9/1/37	0.0533	\$ 810,738	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	PRIVATE BANK		X	WORKING CAPITAL	INT ONLY			2,189,000				39,447	6					
7	IME-RELATED PARTY											4,101	7					
8													8					
9	TOTAL Facility Related				\$85,698.11		\$ 16,088,500	\$ 2,999,738			\$ 854,286	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	\$ 2,999,738			\$ 854,286	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 76,091 Line # 36

* 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 2007 report.		\$	644,376	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.)		\$	658,187	2
3. Under or (over) accrual (line 2 minus line 1).		\$	13,811	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	674,642	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.		\$	688,453	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	689,451	8
	2004	720,502	9
	2005	613,021	10
	2006	628,952	11
	2007	658,187	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>532,987.99</u>	\$ <u>532,987.99</u>
2. <u>30-06-313-045-000</u>	<u>NURSING HOME</u>	\$ <u>3,545.11</u>	\$ <u>3,545.11</u>
3. <u>30-06-313-051-000</u>	<u>NURSING HOME</u>	\$ <u>26,106.92</u>	\$ <u>26,106.92</u>
4. <u>30-06-313-052-000</u>	<u>NURSING HOME</u>	\$ <u>6,839.93</u>	\$ <u>6,839.93</u>
5. <u>30-06-313-053-000</u>	<u>NURSING HOME</u>	\$ <u>8,739.68</u>	\$ <u>8,739.68</u>
6. <u>30-06-313-054-000</u>	<u>NURSING HOME</u>	\$ <u>79,967.66</u>	\$ <u>79,967.66</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>658,187.29</u>	\$ <u>658,187.29</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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	TOTALS			\$ 1,500,000	3

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$	\$ 3,490,883	4
5										5
6										6
7	RELATED PARTY			71,700	2,146		2,146			7
8	OFFICE									8
	Improvement Type**									
9	ROOF - REALTY		1998	74,000	1,897	39	1,897		19,630	9
10	WALLCOVERINGS - REALTY		1998	39,379	1,010	39	1,010		10,447	10
11	PAINTING - REALTY		1998	12,962	332	39	332		3,438	11
12	WINDOW TREATMENTS - REALTY		1998	38,112	977	39	977		10,110	12
13	FENCE - REALTY		1998	650	17	39	17		173	13
14	NEW WINDOWS - REALTY		1998	20,445	524	39	524		5,423	14
15	PAINTERS SALARIES - REALTY		1998	64,064	1,643	39	1,643		16,996	15
16	NURSE STATION - REALTY		1998	23,100	592	39	592		6,127	16
17	TILING - REALTY		1998	635	17	39	17		170	17
18	BUILT IN CABINETS - REALTY		1998	64,700	1,659	39	1,659		17,164	18
19	NEW COILS FOR AHV - REALTY		1999	6,000	154	39	154		1,465	19
20	NEW BOILER - REALTY		1999	20,328	521	39	521		4,956	20
21	HOT WATER TANK - REALTY		1999	2,750	71	39	71		675	21
22	ROOF - REALTY		1999	29,500	756	39	756		7,191	22
23	PATIO - REALTY		1999	5,080	339	15	339		3,223	23
24	AWNING - REALTY		1999	3,000	200	15	200		1,903	24
25	LIGHTS - REALTY		1999	7,603	195	39	195		1,855	25
26	NURSE CALL STATION - REALTY		1999	1,957	50	39	50		476	26
27	WINDOW TREATMENTS - REALTY		1999	11,207	287	39	287		2,731	27
28	CORRIDOR BORDERS - REALTY		1999	6,154	158	39	158		1,503	28
29	SCREENS - REALTY		2000	3,543	129	27.5	129		1,099	29
30	AIR CONDITIONER REPLACEMENT - REALTY		2001	14,540	529	27.5	529		3,973	30
31	DOOR DETECTOR - REALTY		2001	1,800	65	27.5	65		489	31
32	A/C COMPRESSOR & REBUILT AIR HANDLER - REALTY		2001	22,621	823	27.5	823		6,183	32
33	ROOF VENTILATORS - REALTY		2001	6,898	251	27.5	251		1,886	33
34	BOILER - REALTY		2001	63,746	2,318	27.5	2,318		17,414	34
35	WALK IN FREEZER - REALTY		2001	3,750	136	27.5	136		1,022	35
36	DOOR - REALTY		2001	2,970	108	27.5	108		811	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$	\$ 1,105	37
38	DOORS - REALTY	2001	1,995	72	27.5	72		541	38
39	DOORS - REALTY	2001	1,723	63	27.5	63		473	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		4,702	42
43	ROOF - REALTY	2002	6,150	224	27.5	224		1,458	43
44	ELECTRIC DOOR LOCKING SYSTEM - REALTY	2002	2,326	84	27.5	84		548	44
45	DOORS - REALTY	2002	10,098	367	27.5	367		2,390	45
46	TILING - REALTY	2002	17,815	648	27.5	648		4,220	46
47	SAFETY LOCK SYSTEM - REALTY	2002	5,854	213	27.5	213		1,387	47
48	ELEVATOR REPAIR - REALTY	2002	39,650	1,442	27.5	1,442		9,391	48
49	BOILER - REALTY	2002	9,550	347	27.5	347		2,260	49
50	ELEVATOR - REALTY	2003	100,632	3,659	27.5	3,659		20,359	50
51	PATIO DOORS - REALTY	2003	2,300	84	27.5	84		467	51
52	FLOORING IN ELEVATORS - REALTY	2003	1,155	42	27.5	42		233	52
53	NURSES STATION - REALTY	2003	6,806	247	27.5	247		1,375	53
54	KITCHEN CABINETS - REALTY	2003	2,836	103	27.5	103		574	54
55	KITCHEN FLOORING - REALTY	2003	2,673	97	27.5	97		540	55
56	PATIO TILING & LIGHTING - REALTY	2003	4,688	170	27.5	170		946	56
57	COVE BASE IN ANNEX CORRIDOR - REALTY	2003	824	30	27.5	30		166	57
58	HANDRAILS & BUMPER GUARDS - REALTY	2003	8,565	311	27.5	311		1,731	58
59	LIGHTING FOR CORRIDORS - REALTY	2003	1,410	51	27.5	51		284	59
60	KICKPLATES - REALTY	2003	5,300	193	27.5	193		1,073	60
61	FREIGHT & SALES TAX ON ABOVE IMP. - REALTY	2003	816	30	27.5	30		166	61
62	DOOR ALARM SYSTEM	2004	3,076	112	27.5	112		509	62
63	NEW FLOORING	2004	39,141	1,423	27.5	1,423		6,463	63
64	AIR CONDITIONING CHILLER UNIT	2004	14,876	541	27.5	541		2,457	64
65	TILE FLOORING	2004	4,031	147	27.5	147		667	65
66	FIRE SUPPRESSION SYSTEMS	2004	5,001	182	27.5	182		826	66
67	SHOWER, BATH & TUB ROOMS AND KITCHEN	2004	72,837	2,649	27.5	2,649		12,031	67
68	AIR CONDITIONING UNIT	2004	5,484	199	27.5	199		904	68
69	POWER ROOF EXHAUST UNITS	2005	3,972	145	27.5	145		465	69
70	TOTAL (lines 4 thru 69)		\$ 13,695,604	\$ 356,999		\$ 356,999	\$	\$ 3,737,346	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		\$ 13,695,604	\$ 356,999		\$ 356,999	\$	\$ 3,737,346	1
2	RECLAIM PUMPS	2005	1,770	64	27.5	64		206	2
3	POWER ROOF EXHAUST FANS	2005	3,545	129	27.5	129		414	3
4	GREASE BASIN	2005	11,800	429	27.5	429		1,376	4
5	CUBICAL CURTAINS	2005	3,784	436	5	757	321	2,649	5
6	WALL MOUNTED WATER COOLER	2006	1,808	66	27.5	66		156	6
7	FIRE SUPPRESSION SYSTEM	2006	5,200	189	27.5	189		450	7
8	DOORS	2006	2,150	78	27.5	78		231	8
9	CARPETING	2006	2,690	516	5	538	22	1,395	9
10	ROOF REPAIR - REALTY	2007	4,900	178	27.5	178		185	10
11	BUILDING IMPROVEMENT- REALTY	2006	41,151	1,496	27.5	1,496		3,491	11
12	BUILDING IMPROVEMENT	2007	(41,151)	(1,496)	27.5	(1,496)		(2,930)	12
13	BOILER- REALTY	2008	24,300	884	27.5	884		884	13
14	SPRINKLERS- REALTY	2008	12,879	273	27.5	273		273	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)		\$ 13,770,430	\$ 360,241		\$ 360,584	\$ 343	\$ 3,746,126	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	\$ 1,653,252	\$ 6,293	\$ 103,645	\$ 97,352	10	\$ 1,552,617	71
72	Current Year Purchases	54,399	32,640	2,720	(29,920)	10	2,720	72
73	Fully Depreciated Assets							73
74	REL PARTY	31,078	2,198	2,198			1,554	74
75	TOTALS	\$ 1,738,729	\$ 41,131	\$ 108,563	\$ 67,432		\$ 1,556,891	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)	\$ 17,009,159	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 401,372	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 469,147	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,775	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,303,017	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		\$ 2,016,000			3
4	Additions							4
5								5
6								6
7	TOTAL		309		\$ 2,016,000			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: \$ 20,970 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	SEE SCHEDULE ATTACHED			34,779	18
19					19
20					20
21	TOTAL		\$ _____	\$ 34,779	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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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	39-3	hrs	\$		\$ 138,614	\$		\$ 138,614	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,014			3,014	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			85,373			85,373	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				176,751		176,751	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>supplies</u>	39-8				18,577	9,105		27,682	13
14	TOTAL			\$		\$ 245,578	\$ 185,856		\$ 431,434	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: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 81,186	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (500,000))	3,304,693		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	188,485		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	65,619		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,639,983	\$	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	133,540		15
16	Equipment, at Historical Cost	1,731,344		16
17	Accumulated Depreciation (book methods)	(1,724,840)		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)	\$ 140,044	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,780,027	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 813,781	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,189,000		29
30	Accrued Salaries Payable	230,230		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,519		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	266,238		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,528,768	\$	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)	\$ 3,528,768	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 251,259	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,780,027	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 377,721	1
2	Restatements (describe):		2
3	POST CLOSING ENTRIES	(3,717)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 374,004	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	428,255	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	(551,000)	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)	\$ (122,745)	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)	\$ 251,259	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	\$ 12,502,878	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,502,878	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	140,619	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 140,619	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***	14,797	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,797	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ PRIOR YEARS EXPENSES	5,866	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,866	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,664,160	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,289,502	31
32	Health Care	4,625,108	32
33	General Administration	2,540,179	33
	B. Capital Expense		
34	Ownership	2,180,040	34
	C. Ancillary Expense		
35	Special Cost Centers	431,434	35
36	Provider Participation Fee	169,642	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,235,905	40
41	Income before Income Taxes (line 30 minus line 40)**	428,255	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 428,255	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: 01/01/2008

Ending: 12/31/2008

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	4,240	4,320	\$ 147,604	\$ 34.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,119	21,284	606,988	28.52	3
4	Licensed Practical Nurses	51,187	53,131	1,242,335	23.38	4
5	CNAs & Orderlies	132,698	144,191	1,516,128	10.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,810	9,963	130,975	13.15	8
9	Activity Director					9
10	Activity Assistants	16,187	17,510	161,796	9.24	10
11	Social Service Workers	19,386	21,113	306,941	14.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,147	41,102	398,775	9.70	15
16	Dishwashers					16
17	Maintenance Workers	7,282	7,667	91,910	11.99	17
18	Housekeepers	37,540	40,492	404,830	10.00	18
19	Laundry	14,189	15,355	132,712	8.64	19
20	Administrator	2,091	2,091	130,714	62.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,677	13,386	176,703	13.20	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	1,914	1,970	18,941	9.61	31
32	Other Health Care(specify)	15,164	16,496	237,425	14.39	32
33	Other(specify)	21,700	23,510	236,874	10.08	33
34	TOTAL (lines 1 - 33)	403,331	433,581	\$ 5,941,651 *	\$ 13.70	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	\$ 16,533	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	3,863	10-3	37
38	Nurse Consultant	T	4,332	10-3	38
39	Pharmacist Consultant	H	1,440	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		22,150	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,736	11-3	44
45	Social Service Consultant	E	2,594	12-3	45
46	Other(specify) <u>Physicians</u>	S	6,000	10-3	46
47	<u>Nursing program Consultant</u>		8,693	10-3	47
48	<u>Dental Consultant</u>		3,900	10-3	48
49	TOTAL (lines 35 - 48)		\$ 78,241		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		\$ 130,714	Workers' Compensation Insurance	\$ 112,238	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	68,983	Advertising: Employee Recruitment	775	
	OTHER ADMIN		0	FICA Taxes	446,172	Health Care Worker Background Check	0	
				Employee Health Insurance	207,955	(Indicate # of checks performed)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	13,051	
				EMPLOYEE BENEFITS - OTHER	0	MARKETING/ADV/PROMO	3,002	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	17,475	
				PENSION/PROFIT SHARING PLANS	58,452	MGMT CO ALLOC	4,070	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(13,051)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(3,002)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 130,714	TOTAL (agree to Schedule V, line 22, col.8)	\$ 893,800	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,320	
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			\$ 25,000			\$	Out-of-State Travel	\$
PHILIP ESFORMES,INC,MANAGEMENT FEE			20,000				In-State Travel	0
							Seminar Expense	4,304
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 45,000	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,304
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			59,157					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 59,157					

* 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													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	PAINT/DECORATING	2004	\$ 3,092	3 YRS	\$ 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																									
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18																									
19																									
20	TOTALS		\$ 8,530		\$ 1,410	\$ 2,337	\$ 2,338	\$ 1,413	\$ 517	\$	\$	\$													

Facility Name & ID Number **BURNHAM HEALTHCARE**# **0043398**Report Period Beginning: **01/01/2008**Ending: **12/31/2008****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 \$10,933
- (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. \$ 2,033 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. \$ 169,642
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