

Facility Name & ID Number BURNHAM HEALTHCARE

0043398 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,146	82	4,615	24,843	8
9	SNF/PED					9
10	ICF	83,812	913	6	84,731	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	103,958	995	4,621	109,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.15%

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 4,615

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number

BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	402,864	55,156	16,623	474,643		474,643		474,643		1
2	Food Purchase		480,205		480,205		480,205	(907)	479,298		2
3	Housekeeping	420,690	83,376		504,066		504,066		504,066		3
4	Laundry	130,579	26,197	14,762	171,538		171,538	9,563	181,101		4
5	Heat and Other Utilities			199,103	199,103		199,103	787	199,890		5
6	Maintenance	154,552	87,273	78,109	319,934		319,934	12,426	332,360		6
7	Other (specify):* security	265,257		24,518	289,775		289,775	148	289,923		7
8	TOTAL General Services	1,373,942	732,207	333,115	2,439,264		2,439,264	22,017	2,461,281		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	3,912,171	147,960	24,207	4,084,338		4,084,338		4,084,338		10
10a	Therapy	156,723	5,751	20,524	182,998		182,998		182,998		10a
11	Activities	143,930	31,688	3,509	179,127		179,127		179,127		11
12	Social Services	335,541		3,033	338,574		338,574		338,574		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,548,365	185,399	57,273	4,791,037		4,791,037		4,791,037		16
	C. General Administration										
17	Administrative	108,294		40,000	148,294		148,294	23,917	172,211		17
18	Directors Fees										18
19	Professional Services			76,501	76,501		76,501	24,252	100,753		19
20	Dues, Fees, Subscriptions & Promotions			32,126	32,126		32,126	(7,620)	24,506		20
21	Clerical & General Office Expenses	229,069	42,732	40,854	312,655		312,655	14,841	327,496		21
22	Employee Benefits & Payroll Taxes			955,319	955,319		955,319		955,319		22
23	Inservice Training & Education							25	25		23
24	Travel and Seminar			3,106	3,106		3,106		3,106		24
25	Other Admin. Staff Transportation			14,316	14,316		14,316	1,355	15,671		25
26	Insurance-Prop.Liab.Malpractice			164,731	164,731		164,731	29,400	194,131		26
27	Other (specify):*			316,609	316,609		316,609	(294,662)	21,947		27
28	TOTAL General Administration	337,363	42,732	1,643,562	2,023,657		2,023,657	(208,492)	1,815,165		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,259,670	960,338	2,033,950	9,253,958		9,253,958	(186,475)	9,067,483		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	16,623
	REPAIRS & MAINTENANCE	0
		0
		16,623
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	14,762
		0
		14,762
5	HEAT & OTHER UTILITIES	
	GAS HEAT	62,254
	ELECTRICITY	88,300
	WATER	45,218
	CABLE TV - LOBBY	3,331
		0
		199,103
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,818
	PAINTING & DECORATING	0
	BUILDING REPAIRS	8,249
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	33,217
	ELEVATOR MAINTENANCE & REPAIR	12,885
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	6,072
	FIRE SERVICE	7,162
	PAINTING & DECORATING	2,706
		0
		0
		0
		78,109
7	OTHER	
	SCAVENGER	24,264
	SECURITY SERVICE	254
		0
		0
		24,518
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	13,596
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	5,500
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	1,236
	DENTAL CONSULTANT	3,875
		0
		24,207
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 CONSULTA XVIII B 41-2	4,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	15,999
	SPEECH THERAPY CONSULTANT XVIII B 43-2	125
		20,524
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,509
		0
		3,509
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	3,033
	SOCIAL WORKER XVIII B 45-2	0
		0
		3,033
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
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	40,000
		40,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	25,620
	ADMINISTRATIVE CONSULTANTS XIX C	4,500
	PROFESSIONAL FEES XIX C	46,381
		0
		76,501
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,105
	EMPLOYEE WANT ADS XIX F	1,350
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	15,090
	LICENSES & PERMITS XIX F	2,291
	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	9,580
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	210
	PATIENT BACKGROUND CHECKS XIX F	0
		32,126
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,479
	EQUIPMENT REPAIR & MAINTENANCE	5,380
	OUTSIDE CLERICAL SERVICES	12,000
	PENALTIES / OVERDRAFT CHARGES VI 18	2,133
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,862
	MESSENGER SERVICE	0
		0
		40,854

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	473,391
	UNEMPLOYMENT COMPENSATION XIX D	56,637
	WORKERS COMPENSATION INSURANCE XIX D	136,139
	HOSPITALIZATION INSURANCE XIX D	228,548
	EMPLOYEE BENEFITS - OTHER XIX D	1,631
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	58,973
	CHICAGO HEAD TAX XIX D	0
		0
		955,319
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,106
	TRAVEL XIX G	0
		3,106
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	14,316
		14,316
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	164,731
		164,731
27	OTHER	
	BAD DEBTS VI 24	316,609
		316,609

GRAND TOTAL COLUMN 3 OTHER

2,033,950

**BURNHAM HEALTHCARE
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	480,205
LESS SALES TAX	<u>(907)</u>
NET FOOD	479,298

TOTAL PATIENT CENSUS	109,574
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	328,722

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

PATIENT MEALS	328,722
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	328,722

NET FOOD	479,298
DIVIDE TOTAL MEALS/YEAR	<u>328,722</u>

COST PER MEAL	1.46
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

Facility Name & ID Number

BURNHAM HEALTHCARE

#0043398

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			12,044	12,044		12,044	407,672	419,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,200	33,200		33,200	742,901	776,101			32
33	Real Estate Taxes							718,546	718,546			33
34	Rent-Facility & Grounds			1,990,000	1,990,000		1,990,000	(1,990,000)				34
35	Rent-Equipment & Vehicles			57,492	57,492		57,492	6,135	63,627			35
36	Other (specify):* IME			24,102	24,102		24,102	50,844	74,946			36
37	TOTAL Ownership			2,116,838	2,116,838		2,116,838	(63,902)	2,052,936			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		153,624	245,055	398,679		398,679		398,679			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,178	169,178		169,178		169,178			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		153,624	414,233	567,857		567,857		567,857			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,259,670	1,113,962	4,565,021	11,938,653		11,938,653	(250,377)	11,688,276			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	31,130	30		9
10	Interest and Other Investment Income	(59,997)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(907)	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	(2,133)	21		18
19	Entertainment		20		19
20	Contributions	(10,080)	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	(316,609)	27		24
25	Fund Raising, Advertising and Promotional	(3,105)	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	(24,726)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (386,427)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	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)	136,050		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 136,050		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (250,377)		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

ID# 0043398
 Report Period Beginning: 01/01/2009
 Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 517	6	1
2	MARKETING SALARIES	(24,066)	21	2
3	MARKETING AUTO LEASES	(1,177)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(24,726)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(907)	0	0	0	0	0	0	0	0	0	0	(907)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	9,563	0	0	0	0	0	0	0	0	9,563	4
5	Heat and Other Utilities	0	0	0	787	0	0	0	0	0	0	0	787	5
6	Maintenance	517	4,923	3,357	3,629	0	0	0	0	0	0	0	12,426	6
7	Other (specify):*	0	0	109	39	0	0	0	0	0	0	0	148	7
8	TOTAL General Services	(390)	4,923	13,029	4,455	0	0	0	0	0	0	0	22,017	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	9,044	14,873	0	0	0	0	0	0	0	0	23,917	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	886	11,250	116	12,000	0	0	0	0	0	0	24,252	19
20	Fees, Subscriptions & Promotions	(13,185)	0	5,505	60	0	0	0	0	0	0	0	(7,620)	20
21	Clerical & General Office Expenses	(27,376)	12,201	29,998	18	0	0	0	0	0	0	0	14,841	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	25	0	0	0	0	0	0	0	0	25	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	424	931	0	0	0	0	0	0	0	0	1,355	25
26	Insurance-Prop.Liab.Malpractice	0	1,600	372	210	27,218	0	0	0	0	0	0	29,400	26
27	Other (specify):*	(316,609)	13,923	8,024	0	0	0	0	0	0	0	0	(294,662)	27
28	TOTAL General Administration	(357,170)	38,078	70,978	404	39,218	0	0	0	0	0	0	(208,492)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(357,560)	43,001	84,007	4,859	39,218	0	0	0	0	0	0	(186,475)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	31,130	99	227	2,234	373,982	0	0	0	0	0	0	407,672	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(59,997)	0	0	3,969	798,929	0	0	0	0	0	0	742,901	32
33	Real Estate Taxes	0	0	0	3,081	715,465	0	0	0	0	0	0	718,546	33
34	Rent-Facility & Grounds	0	0	0	0	(1,990,000)	0	0	0	0	0	0	(1,990,000)	34
35	Rent-Equipment & Vehicles	0	809	4,342	984	0	0	0	0	0	0	0	6,135	35
36	Other (specify):*	0	0	0	(24,102)	74,946	0	0	0	0	0	0	50,844	36
37	TOTAL Ownership	(28,867)	908	4,569	(13,834)	(26,678)	0	0	0	0	0	0	(63,902)	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)	(386,427)	43,909	88,576	(8,975)	12,540	0	0	0	0	0	0	(250,377)	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	\$ 27,500	EMI ENTERPRISE		\$	(27,500)	1	
2	V	6				4,923	4,923	2	
3	V	17				25,225	25,225	3	
4	V	17				11,319	11,319	4	
5	V	19				886	886	5	
6	V	21				12,201	12,201	6	
7	V	25				424	424	7	
8	V	26				1,600	1,600	8	
9	V	27				13,923	13,923	9	
10	V	30				99	99	10	
11	V	35				809	809	11	
12	V							12	
13	V							13	
14	Total		\$ 27,500			\$ 71,409	\$ *	43,909	14

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

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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)	15
16	V	4	HOUSEKEEPING SALARIES			9,563	9,563	16
17	V	6	PAINTERS' SALARIES			3,357	3,357	17
18	V	7	SCAVENGER			109	109	18
19	V	17	CFO SALARY - A. WEINFELD			14,873	14,873	19
20	V	19	PROFESSIONAL FEES			11,250	11,250	20
21	V	20	WANT ADS / BACKGRD CKS			5,505	5,505	21
22	V	21	OFFICE EXPENSE			41,998	41,998	22
23	V	23	SEMINARS			25	25	23
24	V	25	TRANSPORTATION			931	931	24
25	V	26	INSURANCE			372	372	25
26	V	27	EMPLOYEE BENEFITS			8,024	8,024	26
27	V	30	DEPRECIATION S.L.			227	227	27
28	V	35	EQUIPMENT RENT			4,342	4,342	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		\$ 12,000			\$ 100,576	\$ * 88,576	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 24,102	IME REALTY CORP		\$	\$ (24,102)
16	V	5 UTILITIES				787	787
17	V	6 PAINTERS FEES				1,585	1,585
18	V	6 REPAIRS / MAINT				2,044	2,044
19	V	7 ALARM SERVICE				39	39
20	V	19 PROFESSIONAL FEES				116	116
21	V	21 OFFICE EXPENSE				18	18
22	V	26 INSURANCE				210	210
23	V	30 DEPRECIATION S/L				2,234	2,234
24	V	32 INTEREST				3,969	3,969
25	V	33 R/E TAX				3,081	3,081
26	V	35 STORAGE FEES				984	984
27	V	20 LICENSES & PERMIT				60	60
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			\$ 15,127	\$ * (8,975)

* 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	\$ 1,990,000	BURNHAM HEALTH CARE REALTY		\$	\$ (1,990,000)	15
16	V	19	PROFESSIONAL FEES				12,000	12,000	16
17	V	26	INSURANCE				27,218	27,218	17
18	V	30	DEPR. S.L. BUILDING & IMP				352,481	352,481	18
19	V	30	DEPR. S.L. EQUIP & FURN				21,501	21,501	19
20	V	32	INTEREST				798,929	798,929	20
21	V	33	REAL ESTATE TAXES				715,465	715,465	21
22	V	36	M.I.P. INSURANCE				74,946	74,946	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			\$ 1,990,000			\$ 2,002,540	\$ * 12,540	39

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

Facility Name & ID Number

BURNHAM HEALTHCARE

#

0043398

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 25,225	17-7	1
2								FR EMI			2
3											3
4	PHILIP ESFORMES	MEMBER	MANAGEMENT	19.00	SEE			MGMT. FEE	40,000	17-3	4
5					ATTACHED						5
6					SCHEDULE						6
7	AVRUM WEINFELD	CFO	FIN. OFFICER					FR EKS	14,873	17-7	7
8											8
9	FLORA WEISS		CLERICAL					COMP EKS	2,164	21-7	9
10											10
11											11
12											12
13								TOTAL	\$ 82,262		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:

01/01/2009

Ending: **2/31/2009**

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	DRIVERS' SALARY	PATIENT DAYS	847,051	14	\$ 38,060	\$ 109,574	\$ 4,923	1
2	17	OFFICER SALARY	PATIENT DAYS	847,051	14	195,000	109,574	25,225	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,051	14	87,500	109,574	11,319	3
4	19	ACCOUNTING FEES	PATIENT DAYS	847,051	14	6,850	109,574	886	4
5	21	OFFICE	PATIENT DAYS	847,051	14	94,319	109,574	12,201	5
6	25	TRANSPORTATION	PATIENT DAYS	847,051	14	3,276	109,574	424	6
7	26	INSURANCE	PATIENT DAYS	847,051	14	12,367	109,574	1,600	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	107,628	109,574	13,923	8
9	30	DEPRECIATION S/L	PATIENT DAYS	847,051	14	765	109,574	99	9
10	35	AUTO LEASE	PATIENT DAYS	847,051	14	6,253	109,574	809	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					\$ 552,018	\$ 378,811	\$ 71,409	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2009

Ending: **2/31/2009**

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	847,051	14	\$ 73,923	\$ 73,923	109,574	\$ 9,563	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	847,051	14	25,953	25,953	109,574	3,357	2
3	7	SCAVENGER	PATIENT DAYS	847,051	14	842		109,574	109	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	847,051	14	114,971	114,971	109,574	14,873	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	847,051	14	86,967	74,170	109,574	11,250	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	847,051	14	42,556		109,574	5,505	6
7	21	OFFICE EXPENSE	PATIENT DAYS	847,051	14	324,660	246,961	109,574	41,998	7
8	23	SEMINAR	PATIENT DAYS	847,051	14	190		109,574	25	8
9	25	TRANSPORTATION	PATIENT DAYS	847,051	14	7,194		109,574	931	9
10	26	INSURANCE	PATIENT DAYS	847,051	14	2,872		109,574	372	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	62,031		109,574	8,024	11
12	30	DEPRECIATION S.L	PATIENT DAYS	847,051	14	1,757		109,574	227	12
13	35	EQUIPMENT RENT	PATIENT DAYS	847,051	14	33,562		109,574	4,342	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					\$ 777,478	\$ 535,978		\$ 100,576	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2009

Ending: **2/31/2009**

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	\$ 6,106	\$ 24,102	\$ 787	1
2	6	PAINTERS FEES	INCOME	187,059	15	12,303	24,102	1,585	2
3	6	REPAIRS / MAINT	INCOME	187,059	15	15,863	24,102	2,044	3
4	7	ALARM SERVICE	INCOME	187,059	15	301	24,102	39	4
5	19	PROFESSIONAL FEES	INCOME	187,059	15	897	24,102	116	5
6	21	OFFICE EXPENSE	INCOME	187,059	15	136	24,102	18	6
7	26	INSURANCE	INCOME	187,059	15	1,627	24,102	210	7
8	30	DEPRECIATION	INCOME	187,059	15	17,336	24,102	2,234	8
9	32	INTEREST	INCOME	187,059	15	30,806	24,102	3,969	9
10	33	R/E TAX	INCOME	187,059	15	23,914	24,102	3,081	10
11	35	STORAGE FEES	INCOME	187,059	15	7,635	24,102	984	11
12	20	LICENSES & PERMITS	INCOME	187,059	15	468	24,102	60	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					\$ 117,392	\$	\$ 15,127	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2009

Ending: **2/31/2009**

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	27,218	1	27,218	2
3	30	DEPR. S.L. BUILDING & IMP	DIRECT COST	1	1	352,481	1	352,481	3
4	30	DEPR. S.L. EQUIP & FURN	DIRECT COST	1	1	21,501	1	21,501	4
5	32	INTEREST	DIRECT COST	1	1	798,929	1	798,929	5
6	33	REAL ESTATE TAXES	DIRECT COST	1	1	715,465	1	715,465	6
7	36	M.I.P. INSURANCE	DIRECT COST	1	1	74,946	1	74,946	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					\$ 2,002,540	\$	\$ 2,002,540	25

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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										
										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		X	MORTGAGE			\$		\$ 14,883,574		\$ 798,929	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6		X	WORKING CAPITAL	INTEREST	REVOLV			REVOLV	PRIME +	33,200	6								
7	X									3,969	7								
8											8								
9						\$		\$ 14,883,574		\$ 836,098	9								
B. Non-Facility Related*																			
10		X	LATE FEES								10								
11											11								
12											12								
13											13								
14						\$		\$		\$	14								
15						\$		\$ 14,883,574		\$ 836,098	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 74,946 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

1. Real Estate Tax accrual used on 2008 report.		\$	674,642	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.)		\$	683,099	2
3. Under or (over) accrual (line 2 minus line 1).		\$	8,457	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	707,008	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.		\$	715,465	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	720,502	8
	2005	613,021	9
	2006	628,952	10
	2007	658,187	11
	2008	683,099	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

(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>554,066.02</u>	\$ <u>554,066.02</u>
2. <u>30-06-313-045-000</u>	<u>NURSING HOME</u>	\$ <u>3,713.85</u>	\$ <u>3,713.85</u>
3. <u>30-06-313-051-000</u>	<u>NURSING HOME</u>	\$ <u>27,155.57</u>	\$ <u>27,155.57</u>
4. <u>30-06-313-052-000</u>	<u>NURSING HOME</u>	\$ <u>7,075.11</u>	\$ <u>7,075.11</u>
5. <u>30-06-313-053-000</u>	<u>NURSING HOME</u>	\$ <u>7,831.10</u>	\$ <u>7,831.10</u>
6. <u>30-06-313-054-000</u>	<u>NURSING HOME</u>	\$ <u>83,257.47</u>	\$ <u>83,257.47</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>683,099.12</u>	\$ <u>683,099.12</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

Facility Name & ID Number BURNHAM HEALTHCARE# 0043398

Report Period Beginning:

01/01/2009

Ending:

12/31/2009**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	\$	\$ 3,815,234	4
5											5
6											6
7	RELATED PARTY				71,100	2,146	39	2,146			7
8	OFFICE										8
	Improvement Type**										
9	ROOF - REALTY		1998		74,000	1,897	39	1,897		21,527	9
10	WALLCOVERINGS - REALTY		1998		39,379	1,010	39	1,010		11,457	10
11	PAINTING - REALTY		1998		12,962	332	39	332		3,770	11
12	WINDOW TREATMENTS - REALTY		1998		38,112	977	39	977		11,087	12
13	FENCE - REALTY		1998		650	17	39	17		190	13
14	NEW WINDOWS - REALTY		1998		20,445	524	39	524		5,947	14
15	PAINTERS SALARIES - REALTY		1998		64,064	1,643	39	1,643		18,639	15
16	NURSE STATION - REALTY		1998		23,100	592	39	592		6,719	16
17	TILING - REALTY		1998		635	17	39	17		187	17
18	BUILT IN CABINETRY - REALTY		1998		64,700	1,659	39	1,659		18,823	18
19	NEW COILS FOR AHV - REALTY		1999		6,000	154	39	154		1,619	19
20	NEW BOILER - REALTY		1999		20,328	521	39	521		5,477	20
21	HOT WATER TANK - REALTY		1999		2,750	71	39	71		746	21
22	ROOF - REALTY		1999		29,500	756	39	756		7,947	22
23	PATIO - REALTY		1999		5,080	339	15	339		3,562	23
24	AWNING - REALTY		1999		3,000	200	15	200		2,103	24
25	LIGHTS - REALTY		1999		7,603	195	39	195		2,050	25
26	NURSE CALL STATION - REALTY		1999		1,957	50	39	50		526	26
27	WINDOW TREATMENTS - REALTY		1999		11,207	287	39	287		3,018	27
28	CORRIDOR BORDERS - REALTY		1999		6,154	158	39	158		1,661	28
29	SCREENS - REALTY		2000		3,543	129	27.5	129		1,228	29
30	AIR CONDITIONER REPLACEMENT - REALTY		2001		14,540	529	27.5	529		4,502	30
31	DOOR DETECTOR - REALTY		2001		1,800	65	27.5	65		554	31
32	A/C COMPRESSOR & REBUILT AIR HANDLER - REALTY		2001		22,621	823	27.5	823		7,006	32
33	ROOF VENTILATORS - REALTY		2001		6,898	251	27.5	251		2,137	33
34	BOILER - REALTY		2001		63,746	2,318	27.5	2,318		19,732	34
35	WALK IN FREEZER - REALTY		2001		3,750	136	27.5	136		1,158	35
36	DOOR - REALTY		2001		2,970	108	27.5	108		919	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:

01/01/2009 Ending: 12/31/2009

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 DRYER EXHAUST FAN - REALTY	2001	\$ 4,050	\$ 147	27.5	\$ 147	\$	\$ 1,252	37
38 DOORS - REALTY	2001	1,995	72	27.5	72		613	38
39 DOORS - REALTY	2001	1,723	63	27.5	63		536	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		5,424	42
43 ROOF - REALTY	2002	6,150	224	27.5	224		1,682	43
44 ELECTRIC DOOR LOCKING SYSTEM - REALTY	2002	2,326	84	27.5	84		632	44
45 DOORS - REALTY	2002	10,098	367	27.5	367		2,757	45
46 TILING - REALTY	2002	17,815	648	27.5	648		4,868	46
47 SAFETY LOCK SYSTEM - REALTY	2002	5,854	213	27.5	213		1,600	47
48 ELEVATOR REPAIR - REALTY	2002	39,650	1,442	27.5	1,442		10,833	48
49 BOILER - REALTY	2002	9,550	347	27.5	347		2,607	49
50 ELEVATOR - REALTY	2003	100,632	3,659	27.5	3,659		24,018	50
51 PATIO DOORS - REALTY	2003	2,300	84	27.5	84		551	51
52 FLOORING IN ELEVATORS - REALTY	2003	1,155	42	27.5	42		275	52
53 NURSES STATION - REALTY	2003	6,806	247	27.5	247		1,622	53
54 KITCHEN CABINETS - REALTY	2003	2,836	103	27.5	103		677	54
55 KITCHEN FLOORING - REALTY	2003	2,673	97	27.5	97		637	55
56 PATIO TILING & LIGHTING - REALTY	2003	4,688	170	27.5	170		1,116	56
57 COVE BASE IN ANNEX CORRIDOR - REALTY	2003	824	30	27.5	30		196	57
58 HANDRAILS & BUMPER GUARDS - REALTY	2003	8,565	311	27.5	311		2,042	58
59 LIGHTING FOR CORRIDORS - REALTY	2003	1,410	51	27.5	51		335	59
60 KICKPLATES - REALTY	2003	5,300	193	27.5	193		1,266	60
61 FREIGHT & SALES TAX ON ABOVE IMP. - REALTY	2003	816	30	27.5	30		196	61
62 DOOR ALARM SYSTEM	2004	3,076	112	27.5	112		621	62
63 NEW FLOORING	2004	39,141	1,423	27.5	1,423		7,886	63
64 AIR CONDITIONING CHILLER UNIT	2004	14,876	541	27.5	541		2,998	64
65 TILE FLOORING	2004	4,031	147	27.5	147		814	65
66 FIRE SUPPRESSION SYSTEMS	2004	5,001	182	27.5	182		1,008	66
67 SHOWER, BATH & TUB ROOMS AND KITCHEN	2004	72,837	2,649	27.5	2,649		14,680	67
68 AIR CONDITIONING UNIT	2004	5,484	199	27.5	199		1,103	68
69 POWER ROOF EXHAUST UNITS	2005	3,972	145	27.5	145		610	69
70 TOTAL (lines 4 thru 69)		\$ 13,695,004	\$ 356,999		\$ 356,999	\$	\$ 4,092,199	70

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

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 13,695,004	\$ 356,999		\$ 356,999		\$ 4,092,199	1
2	2005	1,770	64	27.5	64		270	2
3	2005	3,545	129	27.5	129		543	3
4	2005	11,800	429	27.5	429		1,805	4
5	2005	3,784	436	5	757	321	3,406	5
6	2006	1,808	66	27.5	66		222	6
7	2006	5,200	189	27.5	189		639	7
8	2006	2,150	78	27.5	78		309	8
9	2006	2,690	310	5	538	228	1,933	9
10	2007	4,900	178	27.5	178		363	10
11	2006	41,151	1,496	27.5	1,496		4,987	11
12	2007	(41,151)	(1,496)	27.5	(1,496)		(4,426)	12
13	2008	24,300	884	27.5	884		1,768	13
14	2008	12,879	468	27.5	468		741	14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 13,769,830	\$ 360,230		\$ 360,779	\$ 549	\$ 4,104,759	34

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

Facility Name & ID Number **BURNHAM HEALTHCARE**

0043398

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 444,463	\$ 6,441	\$ 37,022	\$ 30,581	10 YRS	\$ 359,292	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,231,480					1,231,480	73
74	RELATED PARTY	63,383	21,915	21,915				74
75	TOTALS	\$ 1,739,326	\$ 28,356	\$ 58,937	\$ 30,581		\$ 1,590,772	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)	\$ 17,009,156	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 388,586	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 419,716	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,130	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,695,531	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		\$ 1,990,000			3
4	Additions							4
5								5
6								6
7	TOTAL		309		\$ 1,990,000			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: \$ **21,748** 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			\$	35,744	17
18					18
19					19
20					20
21	TOTAL		\$	35,744	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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?</p> <p><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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 117,016	\$		\$ 117,016	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,460			6,460	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			121,579			121,579	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				145,270		145,270	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,lab</u>	39-2					8,354		8,354	13
14	TOTAL			\$		\$ 245,055	\$ 153,624		\$ 398,679	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: **01/01/2009**

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 315,291	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 450,000)	1,034,434		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	235,364		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)	\$ 1,650,708	\$	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	1,699,636		16
17	Accumulated Depreciation (book methods)	(1,736,884)		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)	\$ 96,292	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,747,000	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 918,405	\$	26
27	Officer's Accounts Payable	246,612		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	257,473		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,136		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,452,626	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,452,626	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 294,374	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,747,000	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 251,259	1
2	Restatements (describe):		2
3	POST CLOSING ENTRIES	(3,174)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 248,085	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	349,655	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	(303,366)	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)	\$ 46,289	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)	\$ 294,374	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	\$ 12,178,294	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,178,294	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	113,787	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 113,787	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***	59,997	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 59,997	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ PRIOR YEARS EXPENSES	(63,770)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (63,770)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,288,308	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,439,264	31
32	Health Care	4,791,037	32
33	General Administration	2,023,657	33
B. Capital Expense			
34	Ownership	2,116,838	34
C. Ancillary Expense			
35	Special Cost Centers	398,679	35
36	Provider Participation Fee	169,178	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,938,653	40
41	Income before Income Taxes (line 30 minus line 40)**	349,655	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 349,655	43

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

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

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

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

Facility Name & ID Number BURNHAM HEALTHCARE

0043398

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	2,362	2,574	\$ 104,565	\$ 40.62	1
2	Assistant Director of Nursing	1,381	1,448	44,427	30.68	2
3	Registered Nurses	16,670	17,438	477,660	27.39	3
4	Licensed Practical Nurses	55,233	57,047	1,337,741	23.45	4
5	CNAs & Orderlies	140,002	152,087	1,662,201	10.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,962	11,923	156,723	13.14	8
9	Activity Director	1,464	1,640	23,654	14.42	9
10	Activity Assistants	12,573	13,755	120,276	8.74	10
11	Social Service Workers	21,489	23,122	335,541	14.51	11
12	Dietician					12
13	Food Service Supervisor	2,126	2,243	48,729	21.72	13
14	Head Cook	33,926	37,191	354,135	9.52	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	9,557	9,986	132,493	13.27	17
18	Housekeepers	36,892	40,372	420,690	10.42	18
19	Laundry	13,224	14,527	130,579	8.99	19
20	Administrator	2,025	2,070	108,294	52.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,344	16,457	229,069	13.92	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	2,002	2,088	24,606	11.78	31
32	Other Health Care(specify)	16,640	18,042	260,971	14.46	32
33	Other(specify)	29,701	30,941	287,316	9.29	33
34	TOTAL (lines 1 - 33)	423,573	454,951	\$ 6,259,670 *	\$ 13.76	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	\$ 16,623	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	1,236	10-3	38
39	Pharmacist Consultant	H	13,596	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	4,400	10a-3	41
42	Respiratory Therapy Consultant		15,999	10a-3	42
43	Speech Therapy Consultant	F	125	10a-3	43
44	Activity Consultant	E	3,509	11-3	44
45	Social Service Consultant	E	3,033	12-3	45
46	Other(specify) <u>PHYSICIANS</u>	S	5,500	10-3	46
47	<u>DENTAL CONSULTANT</u>		3,875	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 73,896		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				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		\$ 16,000	Workers' Compensation Insurance		\$ 136,139	IDPH License Fee	\$
KAREN GUTIERREZ	ADMINISTRATOR		25,316	Unemployment Compensation Insurance		56,637	Advertising: Employee Recruitment	1,350
MARCITA CARTER	ADMINISTRATOR		66,978	FICA Taxes		473,391	Health Care Worker Background Check	210
				Employee Health Insurance		228,548	(Indicate # of checks performed <u>21</u>)	
				Employee Meals		0	Patient Background Checks	0
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	10,080
				EMPLOYEE BENEFITS - OTHER		1,631	MARKETING/ADV/PROMO	3,105
				EMPLOYEE PHYSICAL EXAMS		0	LICENSES/DUES/SUBSCRIPTIONS	17,381
				PENSION/PROFIT SHARING PLANS		58,973	MGMT CO ALLOC	5,565
				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(10,080)
				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(3,105)
							Yellow page advertising	(0)
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 108,294	TOTAL (agree to Schedule V, line 22, col.8)		\$ 955,319	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,506
(List each licensed administrator separately.)								
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			\$ 27,500			\$	Out-of-State Travel	\$
PHILIP ESFORMES, MANAGEMENT FEE			12,500					
							In-State Travel	0
							Seminar Expense	3,106
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 40,000	TOTAL		\$	Entertainment Expense	()
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services							TOTAL	\$ 3,106
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			76,501					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 76,501					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* 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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	2006	\$ 3,105	3 YRS	\$ 518	\$ 1,035	\$ 1,035	\$ 517	\$	\$	\$	\$
2												
3												
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17												
18												
19												
20	TOTALS		\$ 3,105		\$ 518	\$ 1,035	\$ 1,035	\$ 517	\$	\$	\$	\$

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 \$14,337
- (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. \$ 2,271 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: _____
- (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.