FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0043398

Facility Name: BURNHAM HEALTHCARE

Address: 14500 SOUTH MANISTEE (Number) BURNHAM (City) 60633 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,052	174	11,113	35,339	8
9	SNF/PED					9
10	ICF	73,095	605	128	73,828	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	97,147	779	11,241	109,167	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.79%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 03/01/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 11,073

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	435,394	59,911	16,251	511,556		511,556		511,556			1
2	Food Purchase		517,603		517,603	(11,242)	506,361	(605)	505,756			2
3	Housekeeping	461,572	81,861		543,433		543,433	1,550	544,983			3
4	Laundry	122,993	33,362	15,979	172,334		172,334		172,334			4
5	Heat and Other Utilities			236,231	236,231		236,231	744	236,975			5
6	Maintenance	196,636	59,826	102,292	358,754		358,754	13,977	372,731			6
7	Other (specify):* SECURITY	218,326		114,251	332,577		332,577	134	332,711			7
8	TOTAL General Services	1,434,921	752,563	485,004	2,672,488	(11,242)	2,661,246	15,800	2,677,046			8
	B. Health Care and Programs											
9	Medical Director			6,400	6,400		6,400		6,400			9
10	Nursing and Medical Records	3,966,826	174,691	26,474	4,167,991		4,167,991		4,167,991			10
10a	Therapy	185,388	3,668	42,701	231,757		231,757		231,757			10a
11	Activities	139,267	27,343	4,965	171,575		171,575		171,575			11
12	Social Services	280,621		8,226	288,847		288,847		288,847			12
13	CNA Training											13
14	Program Transportation			460	460		460		460			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,572,102	205,702	89,226	4,867,030		4,867,030		4,867,030			16
	C. General Administration											
17	Administrative	128,901		532,500	661,401		661,401	(304,183)	357,218			17
18	Directors Fees											18
19	Professional Services			54,722	54,722		54,722	28,121	82,843			19
20	Dues, Fees, Subscriptions & Promotions			38,265	38,265		38,265	(9,366)	28,899			20
21	Clerical & General Office Expenses	240,629	38,172	109,321	388,122		388,122	(43,551)	344,571			21
22	Employee Benefits & Payroll Taxes			1,036,782	1,036,782	11,242	1,048,024		1,048,024			22
23	Inservice Training & Education			4,550	4,550		4,550	23	4,573			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			16,867	16,867		16,867	1,836	18,703			25
26	Insurance-Prop.Liab.Malpractice			163,054	163,054		163,054	27,328	190,382			26
27	Other (specify):*			105,159	105,159		105,159	(81,100)	24,059			27
28	TOTAL General Administration	369,530	38,172	2,061,220	2,468,922	11,242	2,480,164	(380,892)	2,099,272			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,376,553	996,437	2,635,450	10,008,440		10,008,440	(365,092)	9,643,348			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.

Facility Name & ID#: BURNHAM HEALTHCARE **#0043398** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	16,251	
	REPAIRS & MAINTENANCE		0	
			0	16,251
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		15,979	
			0	15,979
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		68,167	
	ELECTRICITY		91,090	
	WATER		73,728	
	CABLE TV - LOBBY		3,246	
			0	236,231
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		10,314	
	PAINTING & DECORATING		1,838	
	BUILDING REPAIRS		6,774	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		58,665	
	ELEVATOR MAINTENANCE & REPAIR		10,181	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,564	
	FIRE SERVICE		8,956	
			0	
			0	
			0	
			0	102,292
7	**OTHER**			
	SCAVENGER		24,817	
	SECURITY SERVICE		89,434	
			0	
			0	114,251
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,400	6,400

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	670	
	RESTORATIVE NURSING CONSULTAN	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	6,000	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,900	
	MDS CONSULTANT		2,308	26,474
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		374	
	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	736	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	41,591	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				42,701
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,965	
			0	4,965
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	8,226	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	8,226
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BURNHAM HEALTHCARE **#0043398** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		460	460
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	532,500	532,500
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	17,048	
	ADMINISTRATIVE CONSULTANTS	XIX C	4,420	
	PROFESSIONAL FEES	XIX C	33,254	
			0	54,722
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,974	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	14,911	
	LICENSES & PERMITS	XIX F	8,760	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	10,860	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	260	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				38,265
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		6,251	
	OUTSIDE CLERICAL SERVICES		11,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	73,937	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,133	
	MESSENGER SERVICE		0	
			0	109,321

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	482,210	
	UNEMPLOYMENT COMPENSATION	XIX D	74,944	
	WORKERS COMPENSATION INSURANC	XIX D	117,760	
	HOSPITALIZATION INSURANCE	XIX D	284,514	
	EMPLOYEE BENEFITS - OTHER	XIX D	725	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	76,629	
	CHICAGO HEAD TAX	XIX D	0	
			0	1,036,782
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,550	
				4,550
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		16,867	
				16,867
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		163,054	
				163,054
27	**OTHER**			
	BAD DEBTS	VI 24	105,159	
				105,159

GRAND TOTAL COLUMN 3 OTHER **2,635,450**

BURNHAM HEALTHCARE
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	517,603
LESS SALES TAX	(605)
NET FOOD	516,998
TOTAL PATIENT CENSUS	109,167
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	327,501
ADD # EMPLOYEE MEALS/DAY	20
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	7,300
PATIENT MEALS	327,501
ADD EMPLOYEE MEALS	7,300
TOTAL MEALS/YEAR	334,801
NET FOOD	516,998
DIVIDE TOTAL MEALS/YEAR	334,801
COST PER MEAL	1.54
TIME EMPLOYEE MEALS	7,300
EMPLOYEE MEAL RECLASSIFICATION	**11,242**
	========

Facility Name & ID Number BURNHAM HEALTHCARE #0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			3,194	3,194		3,194	410,883	414,077			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			753	753		753	738,598	739,351			32
33	Real Estate Taxes							394,546	394,546			33
34	Rent-Facility & Grounds			1,860,000	1,860,000		1,860,000	(1,860,000)				34
35	Rent-Equipment & Vehicles			61,785	61,785		61,785	5,406	67,191			35
36	Other (specify):* IME,			24,102	24,102		24,102	49,669	73,771			36
37	TOTAL Ownership			1,949,834	1,949,834		1,949,834	(260,898)	1,688,936			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		325,605	621,485	947,090		947,090		947,090			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		325,605	790,663	1,116,268		1,116,268		1,116,268			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,376,553	1,322,042	5,375,947	13,074,542		13,074,542	(625,990)	12,448,552			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	30,550	30		9
10	Interest and Other Investment Income	(60,176)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(605)	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	(73,937)	21		18
19	Entertainment		20		19
20	Contributions	(11,360)	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	(105,159)	27		24
25	Fund Raising, Advertising and Promotional	(2,974)	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 SEE PAGE 5A	(25,865)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (249,526)		$	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 Amount	2 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)	(376,464)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (376,464)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (625,990)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					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: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	MARKETING SALARIES	(24,112)	21	2
3	SEC 754 LEASEHOLD IMPROVEMENTS	(588)	30	3
4	MARKETING AUTO LEASES	(1,165)	21	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**	(25,865)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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	(605)	0	0	0	0	0	0	0	0	0	0	(605)	2
3	Housekeeping	0	0	1,550	0	0	0	0	0	0	0	0	1,550	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	744	0	0	0	0	0	0	0	744	5
6	Maintenance	0	5,114	6,145	2,718	0	0	0	0	0	0	0	13,977	6
7	Other (specify):*	0	0	57	77	0	0	0	0	0	0	0	134	7
8	**TOTAL General Services**	(605)	5,114	7,752	3,539	0	0	0	0	0	0	0	15,800	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	(319,031)	14,848	0	0	0	0	0	0	0	0	(304,183)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	843	10,149	129	17,000	0	0	0	0	0	0	28,121	19
20	Fees, Subscriptions & Promotions	(14,334)	0	4,843	125	0	0	0	0	0	0	0	(9,366)	20
21	Clerical & General Office Expenses	(99,214)	14,319	41,309	35	0	0	0	0	0	0	0	(43,551)	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	23	0	0	0	0	0	0	0	0	23	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	295	1,541	0	0	0	0	0	0	0	0	1,836	25
26	Insurance-Prop.Liab.Malpractice	0	1,350	656	156	25,166	0	0	0	0	0	0	27,328	26
27	Other (specify):*	(105,159)	16,113	7,946	0	0	0	0	0	0	0	0	(81,100)	27
28	**TOTAL General Administration**	(218,707)	(286,111)	81,315	445	42,166	0	0	0	0	0	0	(380,892)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(219,312)	(280,997)	89,067	3,984	42,166	0	0	0	0	0	0	(365,092)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	29,962	0	198	2,236	378,487	0	0	0	0	0	0	410,883	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(60,176)	0	0	3,870	794,904	0	0	0	0	0	0	738,598	32
33	Real Estate Taxes	0	0	0	3,133	391,413	0	0	0	0	0	0	394,546	33
34	Rent-Facility & Grounds	0	0	0	0	(1,860,000)	0	0	0	0	0	0	(1,860,000)	34
35	Rent-Equipment & Vehicles	0	623	3,757	1,026	0	0	0	0	0	0	0	5,406	35
36	Other (specify):*	0	0	0	(24,102)	73,771	0	0	0	0	0	0	49,669	36
37	TOTAL Ownership	(30,214)	623	3,955	(13,837)	(221,425)	0	0	0	0	0	0	(260,898)	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)	(249,526)	(280,374)	93,022	(9,853)	(179,259)	0	0	0	0	0	0	(625,990)	45

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MNGT	LINCOLNWOOD	MANAGEMENT
				EMI ENTERPRISE	LINCOLNWOOD	CONSULTING
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		IME REALTY CORP	LINCOLNWOOD	HOME OFFICE
				BURNHAM		
				HELATHCARE		
				REALTY	LINCOLNWOOD	REAL ESTATE

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 352,500	EMI ENTERPRISES, INC		$	$ (352,500)	1
2	V	6	DRIVERS' SALARY				5,114	5,114	2
3	V	17	OFFICER SALARY				25,184	25,184	3
4	V	17	REGIONAL DIRECTOR				8,285	8,285	4
5	V	19	ACCOUNTING FEES				843	843	5
6	V	21	OFFICE				14,319	14,319	6
7	V	25	TRANSPORTATION				295	295	7
8	V	26	INSURANCE				1,350	1,350	8
9	V	27	EMPLOYEE BENEFITS				16,113	16,113	9
10	V	35	AUTO LEASE				623	623	10
11	V								11
12	V								12
13	V								13
14	Total			$ 352,500			$ 72,126	$ * (280,374)	14

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

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 11,000	EKS MANAGEMENT		$	$ (11,000)	15
16	V	3	HOUSEKEEPING SALARIES				1,550	1,550	16
17	V	6	PAINTERS' SALARIES				6,145	6,145	17
18	V	7	SCAVENGER				57	57	18
19	V	17	CFO SALARY - A. WEINFELD				14,848	14,848	19
20	V	19	PROFESSIONAL FEES				10,149	10,149	20
21	V	20	WANT ADS / BACKGRD CKS				4,843	4,843	21
22	V	21	OFFICE EXPENSE				52,309	52,309	22
23	V	23	SEMINARS				23	23	23
24	V	25	TRANSPORTATION				1,541	1,541	24
25	V	26	INSURANCE				656	656	25
26	V	27	EMPLOYEE BENEFITS				7,946	7,946	26
27	V	30	DEPRECIATION S.L.				198	198	27
28	V	35	EQUIPMENT RENT				3,757	3,757	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			$ 11,000			$ 104,022	$ * 93,022	39

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

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 24,102	IME REALTY CORP		$	$ (24,102)	15
16	V	5	UTILITIES				744	744	16
17	V	6	PAINTERS FEES				793	793	17
18	V	6	REPAIRS / MAINT				1,925	1,925	18
19	V	7	ALARM SERVICE				77	77	19
20	V	19	ACCOUNTING FEES				129	129	20
21	V	21	OFFICE EXPENSE				35	35	21
22	V	26	INSURANCE				156	156	22
23	V	30	DEPRECIATION S/L				2,236	2,236	23
24	V	32	INTEREST				3,870	3,870	24
25	V	33	R/E TAX				3,133	3,133	25
26	V	35	STORAGE FEES				1,026	1,026	26
27	V	20	LICENSES & PERMIT				125	125	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			$ 24,102			$ 14,249	$ * (9,853)	39

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

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 1,860,000	BURNHAM HEALTH CARE REALTY		$	$ (1,860,000)	15
16	V	19	PROFESSIONAL FEES				17,000	17,000	16
17	V	26	INSURANCE				25,166	25,166	17
18	V	30	DEPRECIATION				378,487	378,487	18
19	V	32	INTEREST				786,396	786,396	19
20	V	32	AMORT LOAN COST				8,508	8,508	20
21	V	33	REAL ESTATE TAXES				391,413	391,413	21
22	V	36	M.I.P. INSURANCE				73,771	73,771	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			$ 1,860,000			$ 1,680,741	$ * (179,259)	39

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

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	MORRIS ESFORMES	MEMBER	MANAGEMENT	39.61				SALARY	$ 25,184	17-7	1
2											2
3											3
4	PHILIP ESFORMES	MEMBER	MANAGEMENT	17.39	SEE			MGMT. FEE	180,000	17-3	4
5					ATTACHED						5
6					SCHEDULE						6
7	AVRUM WEINFELD	CFO	FIN. OFFICER					SALARY	14,848	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 220,032		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: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: EMI ENTERPRISES, 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 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	845,281	14	$ 39,600	$ 39,600	109,167	$ 5,114	1
2	17	OFFICER SALARY	PATIENT DAYS	845,281	14	195,000	195,000	109,167	25,184	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	845,281	14	64,150	64,150	109,167	8,285	3
4	19	ACCOUNTING FEES	PATIENT DAYS	845,281	14	6,525		109,167	843	4
5	21	OFFICE	PATIENT DAYS	845,281	14	110,874	58,558	109,167	14,319	5
6	25	TRANSPORTATION	PATIENT DAYS	845,281	14	2,287		109,167	295	6
7	26	INSURANCE	PATIENT DAYS	845,281	14	10,450		109,167	1,350	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	124,762		109,167	16,113	8
9	35	AUTO LEASE	PATIENT DAYS	845,281	14	4,824		109,167	623	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					$ 558,472	$ 357,308		$ 72,126	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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 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	3	HOUSEKEEPING SALARIES	PATIENT DAYS	845,281	14	$ 12,000	$ 12,000	109,167	$ 1,550	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	845,281	14	47,580	47,580	109,167	6,145	2
3	7	SCAVENGER	PATIENT DAYS	845,281	14	441		109,167	57	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	845,281	14	114,971	114,971	109,167	14,848	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	845,281	14	78,585	66,116	109,167	10,149	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	845,281	14	37,500		109,167	4,843	6
7	21	OFFICE EXPENSE	PATIENT DAYS	845,281	14	405,027	295,327	109,167	52,309	7
8	23	SEMINAR	PATIENT DAYS	845,281	14	175		109,167	23	8
9	25	TRANSPORTATION	PATIENT DAYS	845,281	14	11,931		109,167	1,541	9
10	26	INSURANCE	PATIENT DAYS	845,281	14	5,077		109,167	656	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	61,528		109,167	7,946	11
12	30	DEPRECIATION S.L	PATIENT DAYS	845,281	14	1,536		109,167	198	12
13	35	EQUIPMENT RENT	PATIENT DAYS	845,281	14	29,093		109,167	3,757	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					$ 805,444	$ 535,994		$ 104,022	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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 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	5	UTILITIES	INCOME	187,059	14	$ 5,775	$	24,102	$ 744	1
2	6	PAINTERS FEES	INCOME	187,059	14	6,152		24,102	793	2
3	6	REPAIRS / MAINT	INCOME	187,059	14	14,941		24,102	1,925	3
4	7	ALARM SERVICE	INCOME	187,059	14	601		24,102	77	4
5	19	ACCOUNTING FEES	INCOME	187,059	14	998		24,102	129	5
6	21	OFFICE EXPENSE	INCOME	187,059	14	274		24,102	35	6
7	26	INSURANCE	INCOME	187,059	14	1,211		24,102	156	7
8	30	DEPRECIATION	INCOME	187,059	14	17,356		24,102	2,236	8
9	32	INTEREST	INCOME	187,059	14	30,039		24,102	3,870	9
10	33	R/E TAX	INCOME	187,059	14	24,313		24,102	3,133	10
11	35	STORAGE FEES	INCOME	187,059	14	7,961		24,102	1,026	11
12	20	LICENSES & PERMITS	INCOME	187,059	14	971		24,102	125	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					$ 110,592	$		$ 14,249	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BURNHAM HEALTH CARE REALTY						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$85,698.11	11/21/03	16,088,500	14,388,592	9/1/37	0.0533	786,396	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN							8,508	3
4												4
5												5
	Working Capital											
6	PRIVATE BANK		X	WORKING CAPITAL	INTEREST	REVOLV					753	6
7	IME - RELLATED PARTY										3,870	7
8												8
9	TOTAL Facility Related				$85,698.11		$ 16,088,500	$ 14,388,592			$ 799,527	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 16,088,500	$ 14,388,592			$ 799,527	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 73,771 **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.)**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 707,008	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.)		$ 542,430	2
3. Under or (over) accrual (line 2 minus line 1).		$ (164,578)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 555,991	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.		$ 391,413	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	613,021	8
2006	628,952	9
2007	658,187	10
2008	683,099	11
2009	542,430	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-06-313-040-000	NURSING HOME	$ 439,505.17	$ 439,505.17
2.	30-06-313-045-000	NURSING HOME	$ 2,888.81	$ 2,888.81
3.	30-06-313-051-000	NURSING HOME	$ 21,639.30	$ 21,639.30
4.	30-06-313-052-000	NURSING HOME	$ 5,463.84	$ 5,463.84
5.	30-06-313-053-000	NURSING HOME	$ 6,116.36	$ 6,116.36
6.	30-06-313-054-000	NURSING HOME	$ 66,816.36	$ 66,816.36
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 542,429.84	$ 542,429.84

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 01/01/2010 Ending: 12/31/2010

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 [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	LAND		1998	$ 1,500,000	1
2					2
3	TOTALS			$ 1,500,000	3

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	309		1998		$ 12,649,700	$ 324,351	39	$ 324,351	$	$ 4,139,585	4
5											5
6											6
7	RELATED PARTY					2,149		2,149			7
8	OFFICE										8
	Improvement Type**										
9	ROOF - REALTY			1998	74,000	1,897	39	1,897		23,424	9
10	WALLCOVERINGS - REALTY			1998	39,379	1,010	39	1,010		12,467	10
11	PAINTING - REALTY			1998	12,962	332	39	332		4,102	11
12	WINDOW TREATMENTS - REALTY			1998	38,112	977	39	977		12,064	12
13	FENCE - REALTY			1998	650	17	39	17		207	13
14	NEW WINDOWS - REALTY			1998	20,445	524	39	524		6,471	14
15	PAINTERS SALARIES - REALTY			1998	64,064	1,643	39	1,643		20,282	15
16	NURSE STATION - REALTY			1998	23,100	592	39	592		7,311	16
17	TILING - REALTY			1998	635	17	39	17		204	17
18	BUILT IN CABINETRY - REALTY			1998	64,700	1,659	39	1,659		20,482	18
19	NEW COILS FOR AHV - REALTY			1999	6,000	154	39	154		1,773	19
20	NEW BOILER - REALTY			1999	20,328	521	39	521		5,998	20
21	HOT WATER TANK - REALTY			1999	2,750	71	39	71		817	21
22	ROOF - REALTY			1999	29,500	756	39	756		8,703	22
23	PATIO - REALTY			1999	5,080	339	15	339		3,901	23
24	AWNING - REALTY			1999	3,000	200	15	200		2,303	24
25	LIGHTS - REALTY			1999	7,603	195	39	195		2,245	25
26	NURSE CALL STATION - REALTY			1999	1,957	50	39	50		576	26
27	WINDOW TREATMENTS - REALTY			1999	11,207	287	39	287		3,305	27
28	CORRIDOR BORDERS - REALTY			1999	6,154	158	39	158		1,819	28
29	SCREENS - REALTY			2000	3,543	129	27.5	129		1,357	29
30	AIR CONDITIONER REPLACEMENT - REALTY			2001	14,540	529	27.5	529		5,031	30
31	DOOR DETECTOR - REALTY			2001	1,800	65	27.5	65		619	31
32	A/C COMPRESSOR & REBUILT AIR HANDLER - REALTY			2001	22,621	823	27.5	823		7,829	32
33	ROOF VENTILATORS - REALTY			2001	6,898	251	27.5	251		2,388	33
34	BOILER - REALTY			2001	63,746	2,318	27.5	2,318		22,050	34
35	WALK IN FREEZER - REALTY			2001	3,750	136	27.5	136		1,294	35
36	DOOR - REALTY			2001	2,970	108	27.5	108		1,027	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DRYER EXHAUST FAN - REALTY	2001	$ 4,050	$ 147	27.5	$ 147	$	$ 1,399	37
38	DOORS - REALTY	2001	1,995	72	27.5	72		685	38
39	DOORS - REALTY	2001	1,723	63	27.5	63		599	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		6,146	42
43	ROOF - REALTY	2002	6,150	224	27.5	224		1,906	43
44	ELECTRIC DOOR LOCKING SYSTEM - REALTY	2002	2,326	84	27.5	84		716	44
45	DOORS - REALTY	2002	10,098	367	27.5	367		3,124	45
46	TILING - REALTY	2002	17,815	648	27.5	648		5,516	46
47	SAFETY LOCK SYSTEM - REALTY	2002	5,854	213	27.5	213		1,813	47
48	ELEVATOR REPAIR - REALTY	2002	39,650	1,442	27.5	1,442		12,275	48
49	BOILER - REALTY	2002	9,550	347	27.5	347		2,954	49
50	ELEVATOR - REALTY	2003	100,632	3,659	27.5	3,659		27,677	50
51	PATIO DOORS - REALTY	2003	2,300	84	27.5	84		635	51
52	FLOORING IN ELEVATORS - REALTY	2003	1,155	42	27.5	42		317	52
53	NURSES STATION - REALTY	2003	6,806	247	27.5	247		1,869	53
54	KITCHEN CABINETS - REALTY	2003	2,836	103	27.5	103		780	54
55	KITCHEN FLOORING - REALTY	2003	2,673	97	27.5	97		734	55
56	PATIO TILING & LIGHTING - REALTY	2003	4,688	170	27.5	170		1,286	56
57	COVE BASE IN ANNEX CORRIDOR - REALTY	2003	824	30	27.5	30		226	57
58	HANDRAILS & BUMPER GUARDS - REALTY	2003	8,565	311	27.5	311		2,353	58
59	LIGHTING FOR CORRIDORS - REALTY	2003	1,410	51	27.5	51		386	59
60	KICKPLATES - REALTY	2003	5,300	193	27.5	193		1,459	60
61	FREIGHT & SALES TAX ON ABOVE IMP. - REALTY	2003	816	30	27.5	30		226	61
62	DOOR ALARM SYSTEM	2004	3,076	112	27.5	112		733	62
63	NEW FLOORING	2004	39,141	1,423	27.5	1,423		9,309	63
64	AIR CONDITIONING CHILLER UNIT	2004	14,876	541	27.5	541		3,539	64
65	TILE FLOORING	2004	4,031	147	27.5	147		961	65
66	FIRE SUPPRESSION SYSTEMS	2004	5,001	182	27.5	182		1,190	66
67	SHOWER, BATH & TUB ROOMS AND KITCHEN	2004	72,837	2,649	27.5	2,649		17,329	67
68	AIR CONDITIONING UNIT	2004	5,484	199	27.5	199		1,302	68
69	POWER ROOF EXHAUST UNITS	2005	3,972	145	27.5	145		755	69
70	TOTAL (lines 4 thru 69)		$ 13,623,904	$ 357,002		$ 357,002	$	$ 4,447,052	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 13,623,904	$ 357,002		$ 357,002	$	$ 4,447,052	1
2	RECLAIM PUMPS	2005	1,770	64	27.5	64		334	2
3	POWER ROOF EXHAUST FANS	2005	3,545	129	27.5	129		672	3
4	GREASE BASIN	2005	11,800	429	27.5	429		2,234	4
5	CUBICAL CURTAINS	2005	3,784	217	5	757	540	4,163	5
6	WALL MOUNTED WATER COOLER	2006	1,808	66	27.5	66		288	6
7	FIRE SUPPRESSION SYSTEM	2006	5,200	189	27.5	189		828	7
8	DOORS	2006	2,150	78	27.5	78		387	8
9	CARPETING	2006	2,690	310	5	538	228	2,471	9
10	ROOF REPAIR - REALTY	2007	4,900	178	27.5	178		541	10
11	BUILDING IMPROVEMENT- REALTY	2006	41,151	1,496	27.5	1,496		6,483	11
12	BUILDING IMPROVEMENT	2007	(41,151)	(1,496)	27.5	(1,496)		(5,922)	12
13	BOILER- REALTY	2008	24,300	884	27.5	884		2,652	13
14	SPRINKLERS- REALTY	2008	12,879	468	27.5	468		1,209	14
15	ROOF TOP VENTILATOR	2010	5,345	154	27.5	154		154	15
16	NURSE CALL PANEL ANNUNCIATOR	2010	2,354	68	27.5	68		68	16
17	FURNISH AND INSTALL DOORS-"B" FIRE LABEL	2010	5,102	116	27.5	116		116	17
18	ROOFTOP CHILLER AND CRANKCASE HEATER	2010	11,350	258	27.5	258		258	18
19	NURSE CALL PANEL ANNUNCIATOR	2010	17,440	413	27.5	413		413	19
20	ROOFTOP EXHAUST	2010	13,183	220	27.5	220		220	20
21	FIX ROOF TOPS	2010	2,724	37	27.5	37		37	21
22	BOOSTER HEATER, UNITAIRE FAN COIL UNIT	2010	4,530	69	27.5	69		69	22
23	DURO-LAST ROOF SYSTEM	2010	90,500	411	27.5	411		411	23
24	REPLACEMENT OF THE BOILERS	2010	19,310	146	27.5	146		146	24
25	INSTALL FIRE ALARM PANEL	2010	7,746	12	27.5	12		12	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,878,314	$ 361,918		$ 362,686	$ 768	$ 4,465,296	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: 01/01/2010 Ending: 12/31/2010

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	$ 298,095	$ (2,778)	$ 27,004	$ 29,782	10 YRS	$ 240,246	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,377,848					1,377,848	73
74	RELATED PARTY		24,387	24,387				74
75	TOTALS	$ 1,675,943	$ 21,609	$ 51,391	$ 29,782		$ 1,618,094	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)	$ 17,054,257	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 383,527	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 414,077	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 30,550	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,083,390	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.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
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:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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: ____ *

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.		$
13.		$
14.		$

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: $ 24,117 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	SEE ATTACHED		$	$ 37,668	17
18					18
19					19
20					20
21	TOTAL		$	$ 37,668	21

* 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.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	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	$		$ 333,795	$		$ 333,795	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,694			1,694	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			273,888			273,888	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 prescrpts				325,605		325,605	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): LABORATORY	39-2				12,108			12,108	13
14	TOTAL			$		$ 621,485	$ 325,605		$ 947,090	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.

STATE OF ILLINOIS

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 2,082,200	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (100,000))	184,865		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	229,354		6
7	Other Prepaid Expenses	41,715		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)**	$ 2,603,753	$	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)	(1,739,490)		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 (spe **dept.fixed assets**	12,000		22
23	Other(specify): SEC 754 BASIS ADJ	387,402		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 493,088	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,096,841	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 855,505	$	26
27	Officer's Accounts Payable	237,612		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	281,662		30
31	Accrued Taxes Payable (excluding real estate taxes)	38,108		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)**	$ 1,412,887	$	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)**	$ 1,412,887	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,683,954	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,096,841	$	48

*(See instructions.)

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 294,374	1
2	Restatements (describe):		2
3	THE SEC 754 BASIS ADJUSTMENT	387,990	3
4	IL REPLACEMENT TAX	(3,146)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 679,218	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,553,365	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	(548,629)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,004,736	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,683,954	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,405,106	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,405,106	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	176,231	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 176,231	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***	60,176	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 60,176	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,641,513	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,672,488	31
32	Health Care	4,867,030	32
33	General Administration	2,468,922	33
	B. Capital Expense		
34	Ownership	1,949,834	34
	C. Ancillary Expense		
35	Special Cost Centers	947,090	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)***	$ 13,074,542	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,566,971	41
42	**Income Taxes**	(13,606)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,553,365	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: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,017	2,088	$ 90,250	$ 43.22	1
2	Assistant Director of Nursing	1,266	1,274	41,335	32.45	2
3	Registered Nurses	14,920	15,730	440,348	27.99	3
4	Licensed Practical Nurses	61,352	62,797	1,512,475	24.09	4
5	CNAs & Orderlies	129,046	141,376	1,513,382	10.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,554	12,739	185,388	14.55	8
9	Activity Director					9
10	Activity Assistants	13,630	14,731	139,267	9.45	10
11	Social Service Workers	19,966	21,391	280,621	13.12	11
12	Dietician					12
13	Food Service Supervisor	1,951	2,208	49,152	22.26	13
14	Head Cook	36,315	40,055	386,242	9.64	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	10,362	10,934	144,654	13.23	17
18	Housekeepers	40,526	44,189	461,572	10.45	18
19	Laundry	12,848	13,938	122,993	8.82	19
20	Administrator	2,056	2,101	128,901	61.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,857	17,857	240,629	13.48	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	1,963	1,996	24,513	12.28	31
32	Other Health C: SEE ATTACHED	18,502	19,665	344,523	17.52	32
33	Other(specify) SEE ATTACHED	28,084	29,943	270,308	9.03	33
34	TOTAL (lines 1 - 33)	423,215	455,012	$ 6,376,553 *	$ 14.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 16,251	1-3	35
36	Medical Director	O	6,400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	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	736	10a-3	41
42	Respiratory Therapy Consultant		41,591	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,965	11-3	44
45	Social Service Consultant	E	8,226	12-3	45
46	Other(specify) PHYSICIANS	S	6,000	10a-3	46
47	DENTAL CONSULTANT		3,900	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 101,665		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
FRED BERKOVITS	ADMINISTRATOR	0	$ 120,714
MARCITA CARTER	ADMINISTRATOR	0	8,187
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 128,901

B. Administrative - Other

Description	Amount
EMI ENTERPRISES MANAGEMENT FEE	$ 352,500
PHILIP ESFORMES MANAGEMENT FEE	180,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 532,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		54,722
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 54,722

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,760
Unemployment Compensation Insurance	74,944
FICA Taxes	482,210
Employee Health Insurance	284,514
Employee Meals	11,242
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	725
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	76,629
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,048,024

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	0
Health Care Worker Background Check	260
(Indicate # of checks performed 26)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	11,360
MARKETING/ADV/PROMO	2,974
LICENSES/DUES/SUBSCRIPTIONS	22,676
MGMT CO ALLOC	4,968
TRUST/FRANCHISE/CONTRIB/ETC	(11,360)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,974)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,899

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 $25,770**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,090** 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. $ **11,242** 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 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.