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: 0028696

Facility Name: BIRCHWOOD PLAZA

Address: 1426 WEST BIRCHWOOD (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: (773) 274-4405 **Fax #** (847) 570-0112

HFS ID Number:

Date of Initial License for Current Owners: 06/17/84

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			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) CHARLOTTE KOHN
(Title) EXECUTIVE DIRECTOR

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 BIRCHWOOD PLAZA # 0028696 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	200	Skilled (SNF)	200	73,000	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	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	44,851	10,213	3,432	58,496	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,851	10,213	3,432	58,496	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.13%

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 6/17/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/17/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 200 and days of care provided 3,432

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 BIRCHWOOD PLAZA # 0028696 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	248,120	31,042	11,014	290,176		290,176		290,176			1
2	Food Purchase		300,837		300,837	(22,922)	277,915	(1,458)	276,457			2
3	Housekeeping	212,748	50,976		263,724		263,724		263,724			3
4	Laundry	70,844	16,481	6,284	93,609		93,609		93,609			4
5	Heat and Other Utilities			125,001	125,001		125,001		125,001			5
6	Maintenance	95,377	18,616	40,189	154,182		154,182		154,182			6
7	Other (specify):*			9,177	9,177		9,177		9,177			7
8	TOTAL General Services	627,089	417,952	191,665	1,236,706	(22,922)	1,213,784	(1,458)	1,212,326			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,325,900	173,600	6,036	2,505,536		2,505,536		2,505,536			10
10a	Therapy	167,674			167,674		167,674		167,674			10a
11	Activities	139,082	8,711	2,660	150,453		150,453		150,453			11
12	Social Services	38,102		3,570	41,672		41,672		41,672			12
13	CNA Training											13
14	Program Transportation			80	80		80		80			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,670,758	182,311	18,346	2,871,415		2,871,415		2,871,415			16
	C. General Administration											
17	Administrative	259,639		680,691	940,330		940,330		940,330			17
18	Directors Fees											18
19	Professional Services			78,363	78,363		78,363	12,932	91,295			19
20	Dues, Fees, Subscriptions & Promotions			75,944	75,944		75,944	(65,723)	10,221			20
21	Clerical & General Office Expenses	214,035	21,296	46,852	282,183		282,183		282,183			21
22	Employee Benefits & Payroll Taxes			593,359	593,359	22,922	616,281		616,281			22
23	Inservice Training & Education			1,970	1,970		1,970		1,970			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			8,739	8,739		8,739		8,739			25
26	Insurance-Prop.Liab.Malpractice			140,595	140,595		140,595		140,595			26
27	Other (specify):*											27
28	TOTAL General Administration	473,674	21,296	1,626,513	2,121,483	22,922	2,144,405	(52,791)	2,091,614			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,771,521	621,559	1,836,524	6,229,604		6,229,604	(54,249)	6,175,355			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#: BIRCHWOOD PLAZA **#0028696** **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	11,014	
	REPAIRS & MAINTENANCE		0	
			0	11,014
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		6,284	
			0	6,284
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		42,045	
	ELECTRICITY		58,798	
	WATER		21,409	
	CABLE TV - LOBBY		2,749	
			0	125,001
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,205	
	PAINTING & DECORATING		3,382	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,064	
	ELEVATOR MAINTENANCE & REPAIR		7,248	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		15,785	
	FIRE SERVICE		3,505	
			0	
			0	
			0	
			0	40,189
7	**OTHER**			
	SCAVENGER		9,177	
	SECURITY SERVICE		0	
			0	
			0	9,177
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 CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,416	
	PHARMACY CONSULTANT	XVIII B 39-2	1,620	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	6,036
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	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,160	
	CLERGY		1,500	2,660
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,570	
			0	3,570
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BIRCHWOOD PLAZA **#0028696** **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		80	80
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	680,691	680,691
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,458	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	71,905	
			0	78,363
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	28,476	
	EMPLOYEE WANT ADS	XIX F	1,000	
	CONTRIBUTIONS	VI 20 XIX F	1,100	
	DUES & SUBSCRIPTIONS	XIX F	3,343	
	LICENSES & PERMITS	XIX F	3,868	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	34,872	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	275	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,000	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,450	
	PATIENT BACKGROUND CHECKS	XIX F	560	
				75,944
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,936	
	EQUIPMENT REPAIR & MAINTENANCE		10,067	
	OUTSIDE CLERICAL SERVICES		823	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		34,026	
	MESSENGER SERVICE		0	
			0	46,852

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	282,076	
	UNEMPLOYMENT COMPENSATION	XIX D	17,592	
	WORKERS COMPENSATION INSURANC	XIX D	29,521	
	HOSPITALIZATION INSURANCE	XIX D	237,641	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	5	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	501 PLAN EXPENSE	XIX D	(6,593)	
	CHICAGO HEAD TAX	XIX D	4,474	
	UNION PENSION		28,643	593,359
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,970	
				1,970
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,739	
				8,739
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		140,595	
				140,595
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **1,836,524**

BIRCHWOOD PLAZA
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	300,837
LESS SALES TAX	(1,458)
NET FOOD	299,379
TOTAL PATIENT CENSUS	58,496
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	175,488
ADD # EMPLOYEE MEALS/DAY	40
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	14,600
PATIENT MEALS	175,488
ADD EMPLOYEE MEALS	14,600
TOTAL MEALS/YEAR	190,088
NET FOOD	299,379
DIVIDE TOTAL MEALS/YEAR	190,088
COST PER MEAL	1.57
TIME EMPLOYEE MEALS	14,600
EMPLOYEE MEAL RECLASSIFICATION	**22,922**

PROFESSIONAL FEES
PAGE 21 XIX. C.

ALPHA DATA SERVICES	DATA PROCESSING	5,858
MUTUAL OF OMAHA	DATA PROCESSING	600
RICHARD PEELO	MEDICARE COST REPORT	3,000
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	18,850
MYRON TUSHBAI	ACCOUNTING	10,481
MYERS MILLER	LEGAL	5,213
REIFF SCHRAMM KANTER	LEGAL	15,200
PERSONNEL PLANNING	UNEMPLOYMENT CONSULTANT	1,350
LIFE SAFETY RESOURCES	FIRE CODE CONSULTANT	4,123
ADVANTAGE BENEFITS CONSULTANT	PENSION PLAN CONSULTANT	1,333
MPRO	DISPUTE RESOLUTION SERVICES	1,240
DISALLOWED/PRIOR PERIOD - LEGAL	PAGE 5A LINE 1	8,092
DISALLOWED - MARKETING	PAGE 5A LINE 2	3,023
	PROFESSIONAL FEES	**78,363**

PAGE 3 SCHEDULE V COLUMN 7 LINE 19 **POST-CLOSING LEGAL**

REIFF SCHRAMM KANTER	PAGE 5A LINE 5	15,547
MYERS MILLER	PAGE 5A LINE 6	3,508
		19,055

TRANSPORTATION - STAFF
PAGE 3 SCHEDULE V COLUMN 3 LINE 25

	NAME	PURPOSE	MISC	AUTO ALLOW J GRODETZ
JAN	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		484.62
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	101.84	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	50.27	
FEB	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITI BANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	279.26	
	CESARS CORIA	Gasoline for facility banking, maintenance, marketing & activities	25.00	
MAR	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITI BANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	298.35	
	AMERICAN AIRLINES REBATE		(116.00)	
APR	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CESARS CORIA	Gasoline for facility banking, maintenance, marketing & activities	25.00	
	BRITTANY SHALER	Gasoline for facility banking, maintenance, marketing & activities	16.00	
	CITI BANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	346.50	
MAY	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITI BANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	267.52	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	45.12	
	BRITTANY SHALER	Gasoline for facility banking, maintenance, marketing & activities	24.00	
JUNE	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	JOYCE GRODETZ	Gasoline for facility banking, maintenance, marketing & activities	32.00	
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	1,147.56	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	104.38	
JULY	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		484.62
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	327.21	
	BRITTANY SHALER	Gasoline for facility banking, maintenance, marketing & activities	8.50	
AUG	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	235.52	
	CESARS CORIA	Gasoline for facility banking, maintenance, marketing & activities	35.00	
	BRITTANY SHALER	Gasoline for facility banking, maintenance, marketing & activities	127.50	
SEPT	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	190.45	
	PETTY CASH	Gasoline for facility banking, maintenance, marketing & activities	58.13	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	101.01	
	BRITTANY SHALER	Gasoline for facility banking, maintenance, marketing & activities	56.00	
OCT	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	53.05	
NOV	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	255.76	
	PETTY CASH	Gasoline for facility banking, maintenance, marketing & activities	26.00	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	47.30	
	CESARS CORIA	Gasoline for facility banking, maintenance, marketing & activities	35.00	
DEC	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	335.59	
	TOTAL STAFF TRANSPORTATION:		**4,538.82**	**4,200.04** **8,738.86**

Facility Name & ID Number BIRCHWOOD PLAZA #0028696 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			4,800	4,800		4,800	144,501	149,301			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,757	9,757		9,757	299,268	309,025			32
33	Real Estate Taxes			137,244	137,244		137,244		137,244			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(438,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			4,095	4,095		4,095		4,095			36
37	**TOTAL Ownership**			593,896	593,896		593,896	5,769	599,665			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		136,902	142,084	278,986		278,986		278,986			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		136,902	251,584	388,486		388,486		388,486			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,771,521	758,461	2,682,004	7,211,986		7,211,986	(48,480)	7,163,506			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 BIRCHWOOD PLAZA # 0028696 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 Reference	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	6,342	30		9
10	Interest and Other Investment Income	(1,596)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,458)	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	(275)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(28,476)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(34,872)	20		28
29	Other-Attach Schedule	12,932			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,503)		$	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)	1,023		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,023		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (48,480)		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.		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

BIRCHWOOD PLAZA

ID# 0028696

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DISALLOWED-LEGAL	$ (3,300)	19	1
2	DISALLOWED-MARKETING	(3,023)	19	2
3				3
4	POST-CLOSING ACCRUAL:			4
5	REIFF SCHRAMM KANTER-REAL ESTATE LEGAL	15,747	19	5
6	MYERS MILLER-LEGAL	3,508	19	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**	12,932		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 **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	(1,458)	0	0	0	0	0	0	0	0	0	0	(1,458)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,458)	0	0	0	0	0	0	0	0	0	0	(1,458)	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	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	12,932	0	0	0	0	0	0	0	0	0	0	12,932	19
20	Fees, Subscriptions & Promotions	(65,723)	0	0	0	0	0	0	0	0	0	0	(65,723)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(52,791)	0	0	0	0	0	0	0	0	0	0	(52,791)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(54,249)	0	0	0	0	0	0	0	0	0	0	(54,249)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 **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	6,342	138,159	0	0	0	0	0	0	0	0	0	144,501	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,596)	300,864	0	0	0	0	0	0	0	0	0	299,268	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(438,000)	0	0	0	0	0	0	0	0	0	(438,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,746	1,023	0	0	0	0	0	0	0	0	0	5,769	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)**	(49,503)	1,023	0	0	0	0	0	0	0	0	0	(48,480)	45

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 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
		DOBSON PLAZA INC	EVANSTON, IL	BIRCHWOOD PLAZA ASSOCIATES		REAL ESTATE
					CHICAGO	RENTAL
	SEE ATTACHED					

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	34	RENT	$ 438,000	BIRCHWOOD PLAZA ASSOCIATES		$	$ (438,000)	1
2	V	30	SL DEPRECIATION		" "		138,159	138,159	2
3	V	32	INTEREST		" "		300,864	300,864	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 438,000			$ 439,023	$ * 1,023	14

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 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		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CHARLOTTE KOHN	EXEC. DIRECTOR	MGMT CONSULT	0.00	64,972	27	45.00	MGMT FEES	$ 680,691	17-1	1
2	BARAK KOHN	DIR OF MAINT	SUPERVISION	0.00	41,146	40	64.00	SALARY	46,481	17-1	2
3	CYNTHIA KOHN	BKKP	BKKP	0.00	0	15	100.00	SALARY	44,300	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 771,472		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 BIRCHWOOD PLAZA # 0028696 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 [ ] NO [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										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	TOTALS					$	$		$	25

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 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	RELATED PARTY - BIRCHWOOD PLAZA ASSOCIATES: MORTGAGE						$	$			$	1
2	MB FINANCIAL		X	MORTGAGE	$43,274.00	3/1/2004	6,000,000	4,732,652	3/5/2014	6.0000	295,353	2
3	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS		3/1/2009	27,555	17,911			5,511	3
4												4
5	LEXUS FINANCIAL		X	AUTO LOAN	$853.21	06/15/09	44,566	32,528	06/30/14	5.5000	2,035	5
	Working Capital											
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	$13,744.15	06/01/09	164,930		06/01/10	4.5000	3,551	6
7	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING		06/01/10	130,916		06/01/11	4.5000	2,819	7
8	MB FINANCIAL		X	LETTER OF CREDIT							1,352	8
9	TOTAL Facility Related				$57,871.36		$ 6,367,967	$ 4,783,091			$ 310,621	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,367,967	$ 4,783,091			$ 310,621	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **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 BIRCHWOOD PLAZA # 0028696 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.**	$ 176,180	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.)		$ 155,934	2
3. Under or (over) accrual (line 2 minus line 1).		$ (20,246)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 157,490	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.		$ 137,244	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	172,865	8
	2006	174,865	9
	2007	172,701	10
	2008	174,434	11
	2009	155,934	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 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 BIRCHWOOD PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028696

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.	11-29-302-011-0000	NURSING HOME	$ 3,186.38	$ 3,186.38
2.	11-29-302-012-0000	NURSING HOME	$ 67,587.65	$ 67,587.65
3.	11-29-302-020-0000	NURSING HOME	$ 85,160.21	$ 85,160.21
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 155,934.24	$ 155,934.24

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 BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame STEEL & CONCRETI Number of Stories 3 + BASEMENT

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 [X] (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	RELATED PARTY: BIRCHWOOD PLAZA ASSOC			$	1
2	NURSING HOME		1984	80,569	2
3	TOTALS			$ 80,569	3

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 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	RELATED PARTY: BIRCHWOOD PLAZA ASSOC				$	$		$	$	$	4
5	192		1984		2,238,672		40	55,967	55,967	1,521,127	5
6											6
7											7
8											8
	Improvement Type**										
9	CONCRETE PAVING & RAILS			1984	13,495		20			13,495	9
10	SPRINKLER MODIFICATION			1984	2,752		25			2,752	10
11	LOBBY RENOVATION			1984	2,489		40	62	62	1,660	11
12	TERRACE RESURFACE			1984	7,600		15			7,600	12
13	FOYER RE-FLOORING			1984	1,835		20			1,835	13
14	BASEMENT RENOVATION			1985	18,061		40	452	452	12,163	14
15	NURSING STATION REMODELLING			1985	7,755		20			7,755	15
16	ASPHALT ROOF			1985	7,000		15			7,000	16
17	NURSE CALL SYSTEM REWIRE			1985	4,066		15			4,066	17
18	SPRINKLER MODIFICATION			1985	2,963		25	82	82	2,963	18
19	BASEMENT AWNINGS			1985	1,620		15			1,620	19
20	GRAVEL ROOF			1985	2,700		5			2,700	20
21	CEILING BASEMENT NURSING OFFICE			1985	1,200		20			1,200	21
22	ELEVATOR OVERHAUL			1985	12,800		20			12,800	22
23	VARIOUS (ELECTRIC & SPRINKLER)			1986	5,486		20			5,486	23
24	ELECTRIC PANEL			1988	6,000	190	20		(190)	6,000	24
25	ELECTRICAL IMPROVEMENTS			1990	1,200	38	20	42	4	1,200	25
26	ELEVATOR IMPROVEMENTS			1990	15,600	495	20	415	(80)	15,600	26
27	TUCKPOINTING & BRICKWORK			1990	12,300	390	20	615	225	12,127	27
28	LAUNDRY ROOM DUCTWORK			1990	3,000	95	20	150	55	2,970	28
29	BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR			1994	282,054	7,336	20	14,103	6,767	238,353	29
30	DRAPERY			1994	7,933		5			7,933	30
31	ROOF & PARKING LOT IMPROVEMENTS			1995	69,984	1,992	15	4,231	2,239	69,984	31
32	ENLARGE PATIENT ROOMS(TRANS TO XI-C 97 AUDIT)			1997		149	39		(149)		32
33	WINDOWS			1998	41,775	615	25	1,671	1,056	21,723	33
34	SIDING			1998	20,000	513	25	800	287	10,400	34
35	PATIENT ROOM EXHAUST SYSTEM			1998	9,720	486	20	486		5,913	35
36	ELEVATOR SAFETY DEVICES			1998	5,350	357	15	357		4,403	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 BIRCHWOOD PLAZA # 0028696 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	BUILDING EXTENSION (1994) ALLOWED FOR 1998	1998	$ 49,866	$	20	$ 2,493	$ 2,493	$ 32,409	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		17,353	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		8,039	39
40	CARPETING / DRAPERIES	2000	5,062		7			5,062	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		2,475	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		1,809	42
43	ELEVATOR UPGRADE / FRONT OUTDOOR WALL SYSTEM	2001	89,217	3,244	27.5	3,244		31,224	43
44	CARPETING	2001	8,264		7			8,264	44
45	DRAPERIES	2001	7,753		7			7,753	45
46	WALLPAPER / CARPETTING	2002	18,309		7			18,309	46
47	NURSES STATION	2002	15,101	549	27.5	549		4,735	47
48	WALLPAPER / ELEVATOR UPGRADE	2003	13,835	503	27.5	503		3,908	48
49	WALLPAPER / CARPENTRY	2004	46,774	1,701	27.5	1,701		10,485	49
50	WALLPAPER / CARPENTRY / REMODELING	2005	18,014	655	27.5	655		3,591	50
51	CIRCULATING PUMP	2005	4,139	151	27.5	151		811	51
52	PHONE SYST/WALLPAPER/FLOOR/CARPENTRY/REMODELING	2006	13,703	498	27.5	498		2,449	52
53	FIRE SUPPRESSION SYST/LIGHT FIXTURES	2006	5,719	208	27.5	208		962	53
54	ELEV DOOR RESTRICTOR/PUMP/SENSORS	2006	6,784	247	27.5	247		1,122	54
55	GREASE TRAP/PLUMBING/CONCRETE/THRU-WALL A/C'S	2006	12,014	437	27.5	437		1,948	55
56	NURSING STATION/KITCHEN TILE	2006	14,907	542	27.5	542		2,293	56
57	NURSING STATION/FLOORING/LIGHTING/THRU-WALL A/C'S	2007	11,968	435	27.5	435		1,661	57
58	FLOORING/CARPETING/WALLPAPER	2007	20,700	2,385	7	2,957	572	10,350	58
59	ACCOUSTICAL WALL TILE/FLOOR TILE	2007	5,315	193	27.5	193		654	59
60	LL OFFICE/BATHRMS/TILE/LOCKS/WIRING/THRU-WALL A/C	2008	45,488	1,654	27.5	1,654		4,022	60
61	CARPETING	2008	2,030	207	7	290	83	725	61
62	ROOF	2009	68,700	2,498	27.5	2,498		3,227	62
63	SECURITY SYST/WIRING/CABLE/ELECTRIC OUTLETS	2009	57,237	2,082	27.5	2,082		2,505	63
64	TILE/DRYWALL/TOILETS/SINKS/LIGHT FIXTURES/PAINTING/CARPENTRY/WINDOW FRAMES/FLOORING/COVE BASE/THRU-WALL A/C'S								64
65		2009	24,135	877	27.5	877		1,032	65
66	CARPENTRY/BUILT-INS/MOLDING/TILE/ELECTRIC/CEILING	2009	14,653	533	27.5	533		555	66
67	PAINTING/WALLCOVERING/CARPETING	2009	70,916	11,760	7	10,131	(1,629)	15,196	67
68	MIRRORS/CEILING/LIGHT FIXTURES/RAILS/BUMPERS	2010	13,883	484	27.5	484		484	68
69	ELEVATOR MOTOR/STARTER	2010	5,680	198	27.5	198		198	69
70	TOTAL (lines 4 thru 69)		$ 3,573,270	$ 47,326		$ 115,622	$ 68,296	$ 2,208,438	70

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 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		$ 3,573,270	$ 47,326		$ 115,622	$ 68,296	$ 2,208,438	1
2	FIRE CODE-DAMPERS/DUCTS/SPRINKLERS/WALL EXT/DOOR	2010	45,802	1,041	27.5	1,041		1,041	2
3	BATHROOM TUB/TILES/FIXTURES/PAINTING	2010	18,773	370	27.5	370		370	3
4	BUILT-IN WARDROBES/CABINETS/DOORS/COUNTERTOP	2010	37,056	730	27.5	730		730	4
5	TREES/SHRUBS/PERENNIALS/HARDSCAPE/EPOXY STONE	2010	24,949	831	15	831		831	5
6	SUMP PUMPS & CONTROL PANEL	2010	12,061	238	27.5	238		238	6
7	WALLPAPER/PAINTING/CARPETING/DRAPERIES/CURTAINS	2010	84,560	16,912	7	6,040	(10,872)	6,040	7
8	LIGHT FIXTURES/CIRCUIT PANEL	2010	3,682	61	27.5	61		61	8
9	30 HP COMPRESSOR	2010	15,835	264	27.5	264		264	9
10	PAINTING/CARPETING/TILE/COVE BASE/DRAPERIES	2010	22,385	4,477	7	1,599	(2,878)	1,599	10
11									11
12									12
13									13
14									14
15	ADJUST TO SL			54,546			(54,546)		15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,838,373	$ 126,796		$ 126,796	$	$ 2,219,612	34

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 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	$ 94,470	$ 8,076	$ 8,076	$	5-15 YRS	$ 54,857	71
72	Current Year Purchases	72,001	3,287	3,287		8-15 YRS	3,287	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 166,471	$ 11,363	$ 11,363	$		$ 58,144	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	BANKING,PURCHASING,	'10 LEXUS	2009	$ 44,566	$ 4,800	$ 11,142	$ 6,342	4 YRS	$ 16,713	76
77	ADMINISTRATIVE,ETC									77
78										78
79	FACILITY VAN			13,600				4 YRS	13,600	79
80	TOTALS			$ 58,166	$ 4,800	$ 11,142	$ 6,342		$ 30,313	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)	$ 4,143,579	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 142,959	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,301	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,342	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,308,069	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 BIRCHWOOD PLAZA # 0028696 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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* 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 BIRCHWOOD PLAZA # 0028696 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 BIRCHWOOD PLAZA STATE OF ILLINOIS # 0028696 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	$		$ 109,934	$		$ 109,934	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,900			1,900	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			30,250			30,250	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				117,853		117,853	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					19,049		19,049	13
14	TOTAL			$		$ 142,084	$ 136,902		$ 278,986	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 BIRCHWOOD PLAZA # 0028696 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	$ 192,199	$ 194,742	1
2	Cash-Patient Deposits	78,025	78,025	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	799,927	799,927	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,496	77,496	6
7	Other Prepaid Expenses	13,975	13,975	7
8	Accounts Receivable (owners or related parties)	682,873	897,624	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,844,495	$ 2,061,789	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		80,569	13
14	Buildings, at Historical Cost		2,232,597	14
15	Leasehold Improvements, at Historical Cost		1,618,184	15
16	Equipment, at Historical Cost	44,566	224,637	16
17	Accumulated Depreciation (book methods)	(15,760)	(2,993,880)	17
18	Deferred Charges		17,911	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): NY LIFE INSUR.CONTRACTS	475,090	475,090	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 503,896	$ 1,655,108	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,348,391	$ 3,716,897	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 275,258	$ 278,958	26
27	Officer's Accounts Payable	184,922	184,922	27
28	Accounts Payable-Patient Deposits	78,025	78,025	28
29	Short-Term Notes Payable	74,126	316,036	29
30	Accrued Salaries Payable	142,652	142,652	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,557	15,557	31
32	Accrued Real Estate Taxes(Sch.IX-B)		157,490	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	203,453	203,453	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 973,993	$ 1,377,093	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	23,862	23,862	39
40	Mortgage Payable		4,490,742	40
41	Bonds Payable			41
42	Deferred Compensation	288,323	288,323	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 312,185	$ 4,802,927	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,286,178	$ 6,180,020	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,062,213	$ (2,463,123)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,348,391	$ 3,716,897	48

*(See instructions.)

Facility Name & ID Number BIRCHWOOD PLAZA **#** 0028696 **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**	$ 679,299	1
2	Restatements (describe):		2
3	2009 IL REPLACEMENT TAX	(13,826)	3
4			4
5	ROUNDING	(3)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 665,470	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,556,743	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,160,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 396,743	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)**	$ 1,062,213	24 *

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 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	$ 8,630,631	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,630,631	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	162,588	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 162,588	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	4,631	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)**	$ 4,631	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,596	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,596	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)**	$ 8,799,446	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,236,706	31
32	Health Care	2,871,415	32
33	General Administration	2,121,483	33
	B. Capital Expense		
34	Ownership	593,896	34
	C. Ancillary Expense		
35	Special Cost Centers	278,986	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	4,912	37
38	LOSS ON SALE OF ASSETS	25,805	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,242,703	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,556,743	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,556,743	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 BIRCHWOOD PLAZA # 0028696 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	4,150	4,570	$ 182,723	$ 39.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,667	22,801	757,375	33.22	3
4	Licensed Practical Nurses	10,865	11,357	282,805	24.90	4
5	CNAs & Orderlies	87,535	93,664	1,044,172	11.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,528	6,172	167,674	27.17	8
9	Activity Director					9
10	Activity Assistants	11,684	12,501	139,082	11.13	10
11	Social Service Workers	1,741	1,782	38,102	21.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,019	2,237	51,701	23.11	14
15	Cook Helpers/Assistants	5,979	6,667	87,368	13.10	15
16	Dishwashers	10,287	11,218	109,051	9.72	16
17	Maintenance Workers	4,272	4,426	95,377	21.55	17
18	Housekeepers	16,476	18,160	212,748	11.72	18
19	Laundry	5,952	6,509	70,844	10.88	19
20	Administrator	2,083	2,083	199,772	95.91	20
21	Assistant Administrator	2,005	2,086	59,867	28.70	21
22	Other Administrative					22
23	Office Manager	3,521	3,654	112,956	30.91	23
24	Clerical	4,916	5,128	101,079	19.71	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					31
32	Other Health C: MDS	1,802	1,911	58,825	30.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,482	216,926	$ 3,771,521 *	$ 17.39	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	$ 11,014	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	4,416	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,620	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,160	11-3	44
45	Social Service Consultant	E	3,570	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 27,780		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ABRAHAM SCHIFFMAN	ADMINISTRATOR		$ 199,772
JOYCE GRODETZ	ASST ADMIN		59,867
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 259,639

B. Administrative - Other

Description		Amount
CHARLOTTE KOHN	MANAGEMENT FEES	$ 680,691
TOTAL (agree to Schedule V, line 17, col. 3)		$ 680,691
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		78,363
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 78,363

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,521
Unemployment Compensation Insurance	17,592
FICA Taxes	282,076
Employee Health Insurance	237,641
Employee Meals	22,922
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	0
EMPLOYEE PHYSICAL EXAMS	5
PENSION/PROFIT SHARING PLANS	(6,593)
CHICAGO HEAD TAX	4,474
UNION PENSION	28,643
TOTAL (agree to Schedule V, line 22, col.8)	$ 616,281

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	1,000
Health Care Worker Background Check	1,450
(Indicate # of checks performed 45)	
Patient Background Checks 56	560
TRUST/FRANCHISE/CONTRIB/ETC	2,375
MARKETING/ADV/PROMO	63,348
LICENSES/DUES/SUBSCRIPTIONS	6,216
TRUST/FRANCHISE/CONTRIB/ETC	(2,375)
Less: Public Relations Expense	(0)
Non-allowable advertising	(28,476)
Yellow page advertising	(34,872)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,221

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)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 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													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 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 ASSOC H/C FACIL $2400**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(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. $ **67,177** 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. $ **109,500**
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. $ **22,922** 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.