FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

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: SANFORD BOKOR **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 01/01/2016 to 12/31/2016 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) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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: 01/01/2016 Ending: 12/31/2016

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	73,200	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	73,200	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			4,239	4,239	8
9	SNF/PED					9
10	ICF	44,627	10,088	1,136	55,851	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,627	10,088	5,375	60,090	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.09%

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 4,239

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	279,115	31,146	9,828	320,089		320,089		320,089			1
2	Food Purchase		379,476		379,476	(28,324)	351,152	(1,838)	349,314			2
3	Housekeeping	241,492	60,606		302,098		302,098		302,098			3
4	Laundry	76,019	14,196	4,157	94,372		94,372		94,372			4
5	Heat and Other Utilities			151,875	151,875		151,875		151,875			5
6	Maintenance	95,114	23,593	44,876	163,583		163,583		163,583			6
7	Other (specify):*			5,527	5,527		5,527		5,527			7
8	TOTAL General Services	691,740	509,017	216,263	1,417,020	(28,324)	1,388,696	(1,838)	1,386,858			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,706,561	208,655	14,470	2,929,686		2,929,686		2,929,686			10
10a	Therapy	58,008	2,545	4,598	65,151		65,151		65,151			10a
11	Activities	206,701	7,643	3,800	218,144		218,144		218,144			11
12	Social Services	101,848		2,625	104,473		104,473		104,473			12
13	CNA Training											13
14	Program Transportation			667	667		667		667			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,073,118	218,843	32,160	3,324,121		3,324,121		3,324,121			16
	C. General Administration											
17	Administrative	363,776		1,104,264	1,468,040		1,468,040	(1,014,264)	453,776			17
18	Directors Fees											18
19	Professional Services			111,281	111,281		111,281		111,281			19
20	Dues, Fees, Subscriptions & Promotions			95,815	95,815		95,815	(59,751)	36,064			20
21	Clerical & General Office Expenses	206,824	17,635	35,503	259,962		259,962	(265)	259,697			21
22	Employee Benefits & Payroll Taxes			910,192	910,192	28,324	938,516		938,516			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,456	2,456		2,456		2,456			24
25	Other Admin. Staff Transportation			7,588	7,588		7,588		7,588			25
26	Insurance-Prop.Liab.Malpractice			218,901	218,901		218,901		218,901			26
27	Other (specify):* MARKETING	36,005			36,005		36,005	(36,005)				27
28	TOTAL General Administration	606,605	17,635	2,486,000	3,110,240	28,324	3,138,564	(1,110,285)	2,028,279			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,371,463	745,495	2,734,423	7,851,381		7,851,381	(1,112,123)	6,739,258			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: 01/01/2016** **Ending: 12/31/2016**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,828	
	REPAIRS & MAINTENANCE		0	
				9,828
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,157	
				4,157
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		36,913	
	ELECTRICITY		61,925	
	WATER		46,182	
	CABLE TV - LOBBY		6,855	
				151,875
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,147	
	PAINTING & DECORATING		2,036	
	BUILDING REPAIRS		1,499	
	MAINTENANCE TRAVEL		3,250	
	EQUIPMENT MAINTENANCE & REPAIR		7,830	
	ELEVATOR MAINTENANCE & REPAIR		10,049	
	OUTSIDE LABOR		549	
	EXTERMINATING SERVICE		3,380	
	FIRE SERVICE		10,136	
				44,876
7	**OTHER**			
	SCAVENGER		5,527	
	SECURITY SERVICE		0	
				5,527
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,800	
	PHARMACY CONSULTANT	XVIII B 39-2	9,670	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				14,470
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		2,233	
	SPEECH THERAPY SERVICES		62	
	OCCUPATIONAL THERAPY SERVICES		2,303	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				4,598
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,200	
	CLERGY		2,600	3,800
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,625	
				2,625
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BIRCHWOOD PLAZA **#0028696** **Report Period Beginning: 01/01/2016** **Ending: 12/31/2016**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		667	
				667
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	1,104,264	1,104,264
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	50,794	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	60,487	
				111,281
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	17,275	
	EMPLOYEE WANT ADS	XIX F	29,085	
	CONTRIBUTIONS	VI 20 XIX F	3,650	
	DUES & SUBSCRIPTIONS	XIX F	1,735	
	LICENSES & PERMITS	XIX F	4,054	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	38,726	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	100	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	880	
	PATIENT BACKGROUND CHECKS	XIX F	310	
				95,815
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,436	
	EQUIPMENT REPAIR & MAINTENANCE		12,557	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	265	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		21,245	
	MESSENGER SERVICE		0	
				35,503

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	319,408	
	UNEMPLOYMENT COMPENSATION	XIX D	18,543	
	WORKERS COMPENSATION INSURANC	XIX D	137,789	
	HOSPITALIZATION INSURANCE	XIX D	399,146	
	EMPLOYEE BENEFITS - OTHER	XIX D	52	
	EMPLOYEE PHYSICAL EXAMS	XIX D	490	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	33,436	
	501 PLAN - CASH VALUE ADJ	XIX D	1,328	
				910,192
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,456	
	TRAVEL	XIX G	0	
				2,456
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,588	
				7,588
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		218,901	
				218,901
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **2,734,423**

BIRCHWOOD PLAZA
SCHEDULES
12/31/2016

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

TOTAL FOOD PURCHASE	379,476
LESS SALES TAX	(1,838)
NET FOOD	377,638
TOTAL PATIENT CENSUS	60,090
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	180,270
ADD # EMPLOYEE MEALS/DAY	40
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	14,600
PATIENT MEALS	180,270
ADD EMPLOYEE MEALS	14,600
TOTAL MEALS/YEAR	194,870
NET FOOD	377,638
DIVIDE TOTAL MEALS/YEAR	194,870
COST PER MEAL	1.94
TIMES EMPLOYEE MEALS	14,600
EMPLOYEE MEAL RECLASSIFICATION	**28,324**

Facility Name & ID Number BIRCHWOOD PLAZA #0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,775	1,775		1,775	142,668	144,443			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							276,265	276,265			32
33	Real Estate Taxes			235,324	235,324		235,324		235,324			33
34	Rent-Facility & Grounds			936,000	936,000		936,000	(936,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			7,096	7,096		7,096		7,096			36
37	**TOTAL Ownership**			1,180,195	1,180,195		1,180,195	(517,067)	663,128			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		175,243	721,270	896,513		896,513		896,513			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			444,959	444,959		444,959		444,959			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		175,243	1,166,229	1,341,472		1,341,472		1,341,472			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,371,463	920,738	5,080,847	10,373,048		10,373,048	(1,629,190)	8,743,858			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: 01/01/2016 Ending: 12/31/2016

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	(1,775)	30		9
10	Interest and Other Investment Income	(2,240)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,838)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(100)	20		17
18	Fines and Penalties	(265)	21		18
19	Entertainment				19
20	Contributions	(3,650)	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	(17,275)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(38,726)	20		28
29	Other-Attach Schedule SEE PG 5A	(1,050,269)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,116,138)		$	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)	(513,052)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (513,052)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,629,190)		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: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DISALLOWED EXCESS MANAGEMENT FEE	$ (1,014,264)	17	1
2	DISALLOWED MARKETING SALARY	(36,005)	27	2
3	DISALLOWED MARKETING TRAVEL		12	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,050,269)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	(1,838)	0	0	0	0	0	0	0	0	0	0	(1,838)	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**	(1,838)	0	0	0	0	0	0	0	0	0	0	(1,838)	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	(1,014,264)	0	0	0	0	0	0	0	0	0	0	(1,014,264)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(59,751)	0	0	0	0	0	0	0	0	0	0	(59,751)	20
21	Clerical & General Office Expenses	(265)	0	0	0	0	0	0	0	0	0	0	(265)	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):*	(36,005)	0	0	0	0	0	0	0	0	0	0	(36,005)	27
28	**TOTAL General Administration**	(1,110,285)	0	0	0	0	0	0	0	0	0	0	(1,110,285)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,112,123)	0	0	0	0	0	0	0	0	0	0	(1,112,123)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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	(1,775)	144,443	0	0	0	0	0	0	0	0	0	142,668	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,240)	278,505	0	0	0	0	0	0	0	0	0	276,265	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(936,000)	0	0	0	0	0	0	0	0	0	(936,000)	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**	(4,015)	(513,052)	0	0	0	0	0	0	0	0	0	(517,067)	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)**	(1,116,138)	(513,052)	0	0	0	0	0	0	0	0	0	(1,629,190)	45

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ARTHUR KOHN	75%	DOBSON PLAZA NURSING & REHAB LLC	EVANSTON, IL	BIRCHWOOD PLAZA ASSOCIATES		REAL ESTATE
CHARLOTTE KOHN TRUST	25%				CHICAGO	RENTAL
				CDS LLC		PARKING LOT
					CHICAGO	RENTAL

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	$ 60,000	CDS LLC		$	$ (60,000)	1
2	V								2
3	V	34	RENT	876,000	BIRCHWOOD PLAZA ASSOCIATES			(876,000)	3
4	V	30	SL DEPRECIATION		" "		144,443	144,443	4
5	V	32	INTEREST		" "		278,505	278,505	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			$ 936,000			$ 422,948	$ * (513,052)	14

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	25.00	110,000	27	45.00	MGMT FEES	$ 90,000	17-3	1
2	BARAK KOHN	DIR OF MAINT	SUPERVISION	0.00	28,654	12	40.00	SALARY	11,181	6-1	2
3	CYNTHIA KOHN	OFFICE MGR	OFFICE MGR	0.00	0	20	100.00	SALARY	56,286	23-1	3
4	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	58,666	6	50.00	SALARY	52,666	17-1	4
5	RAMONA WEINGARTEN	MARKETING	MARKETING	0.00	0	30	100.00	SALARY	36,005	27-1	5
6											6
7											7
8											8
9	BY ATTRIBUTION, 100% KOHN FAMILY OWNED										9
10											10
11	CERTAIN AMOUNTS ON THIS PAGE HAVE BEEN ADJUSTED TO REFLECT EXPECTED IL DEPT OF HFS ALLOWABLE LIMITATIONS										11
12											12
13								TOTAL	$ 246,138		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: 01/01/2016 Ending: 2/31/2016

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: 01/01/2016 Ending: 12/31/2016

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	PRIVATE BANK		X	MORTGAGE	$20,000+INT	3/14/2012	9,000,000	8,184,000	3/14/2017	5.2500	250,571	2
3	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS			139,670	5,820			27,934	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 9,139,670	$ 8,189,820			$ 278,505	9
	B. Non-Facility Related*											
10	IRS,IDR,ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,139,670	$ 8,189,820			$ 278,505	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	250,360	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.)	$	252,323	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,963	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	254,850	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** $ 21,489 **For** ### **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$	(21,489)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	235,324	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	162,046	8
	2012	239,745	9
	2013	242,990	10
	2014	247,884	11
	2015	252,323	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 2015 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIRCHWOOD PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028696

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-302-011-0000	NURSING HOME	$ 3,782.51	$ 3,782.51
2.	11-29-302-012-0000	NURSING HOME	$ 102,474.80	$ 102,474.80
3.	11-29-302-020-0000	NURSING HOME	$ 128,247.41	$ 128,247.41
4.	11-29-302-016-0000	NURSING HOME PARKING LOT	$ 7,020.13	$ 7,020.13
5.	11-29-302-017-0000	NURSING HOME PARKING LOT	$ 5,455.76	$ 5,455.76
6.	11-29-302-018-0000	NURSING HOME PARKING LOT	$ 5,342.53	$ 5,342.53
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 252,323.14	$ 252,323.14

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,825 B. General Construction Type: Exterior BRICK Frame STEEL/CONCRETE 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	B P ASSOC - NURSING HOME	27,609	1984	$ 80,569	1
2	CDS LLC - PARKING LOT	23,854	1997	30,081	2
3	TOTALS	51,463		$ 110,650	3

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	1,856,929	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	2,032	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	14,875	14
15	NURSING STATION REMODELLING	per audit -7,755		1985			20				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			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	per audit -12,800		1985			20				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		(38)	1,200	25
26	ELEVATOR IMPROVEMENTS			1990	15,600	495	20		(495)	15,600	26
27	TUCKPOINTING & BRICKWORK			1990	12,300	390	20		(390)	12,300	27
28	LAUNDRY ROOM DUCTWORK			1990	3,000	95	20		(95)	3,000	28
29	BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR			1994	282,054	7,336	20		(7,336)	282,054	29
30	DRAPERY			1994	7,933		5			7,933	30
31	ROOF & PARKING LOT IMPROVEMENTS	per audit -36,500		1995	33,484	1,992	15		(1,992)	33,484	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	31,749	33
34	SIDING			1998	20,000	513	25	800	287	15,200	34
35	PATIENT ROOM EXHAUST SYSTEM			1998	9,720	486	20	486		8,953	35
36	ELEVATOR SAFETY DEVICES			1998	5,350	357	15			5,350	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: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 47,367	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		26,407	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		12,233	39
40	CARPETING / DRAPERIES	2000	5,062		7			5,062	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		3,873	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		2,937	42
43	ELEV UPGRADE/FRONT OUTDooR WALL SYST per audit -1,016	2001	88,201	3,244	27.5	3,244		50,688	43
44	CARPETING	2001	8,264		7			8,264	44
45	DRAPERIES per audit -7,753	2001			7				45
46	WALLPAPER / CARPETING per audit -18,309	2002			7				46
47	NURSES STATION	2002	15,101	549	27.5	549		7,800	47
48	WALLPAPER / ELEVATOR UPGRADE per audit -13,835	2003		503	27.5	503		6,926	48
49	WALLPAPER / CARPENTRY	2004	46,774	1,701	27.5	1,701		20,691	49
50	WALLPAPER / CARPENTRY / REMODELING	2005	18,014	655	27.5	655		7,521	50
51	CIRCULATING PUMP	2005	4,139	150	27.5	150		1,714	51
52	PHONE SYST/WALLPAPER/FLOOR/CARPENTRY/REMODELING	2006	13,703	498	27.5	498		5,437	52
53	FIRE SUPPRESSION SYST/LIGHT FIXTURES	2006	5,719	208	27.5	208		2,210	53
54	ELEV DOOR RESTRICTOR/PUMP/SENSORS	2006	6,784	247	27.5	247		2,604	54
55	GREASE TRAP/PLUMBING/CONCRETE/THRU-WALL A/C'S	2006	12,014	437	27.5	437		4,570	55
56	NURSING STATION/KITCHEN TILE	2006	14,907	542	27.5	542		5,545	56
57	NURSING STATION/FLOORING/LIGHTING/THRU-WALL A/C'S	2007	11,968	435	27.5	435		4,271	57
58	FLOORING/CARPETING/WALLPAPER	2007	20,700		7			20,700	58
59	ACCOUSTICAL WALL TILE/FLOOR TILE	2007	5,315	193	27.5	193		1,812	59
60	LL OFFICE/BATHRMS/TILE/LOCKS/WIRING/THRU-WALL A/C	2008	45,488	1,654	27.5	1,654		13,946	60
61	CARPETING per audit -2,030	2008		115	7		(115)		61
62	ROOF	2009	68,700	2,498	27.5	2,498		18,215	62
63	SECURITY SYST/WIRING/CABLE/OUTLETS per audit -7,500	2009	49,737	2,082	27.5	2,082		14,997	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		6,294	65
66	CARPENTRY/BUILT-INS/MOLDING/TILE/ELECTRIC/CEILING	2009	14,653	533	27.5	533		3,754	66
67	PAINTING/WALLCOVERING/CARPETING	2009	70,916		7	5,065	5,065	70,916	67
68	MIRRORS/CEILING/LIGHT FIXTURES/RAILS/BUMPERS	2010	13,883	505	27.5	505		3,514	68
69	ELEVATOR MOTOR/STARTER	2010	5,680	207	27.5	207		1,440	69
70	TOTAL (lines 4 thru 69)		$ 3,465,772	$ 33,118		$ 87,343	$ 54,582	$ 2,729,084	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: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 3,465,772	$ 33,118		$ 87,343	$ 54,225	$ 2,729,084	1
2	FIRE CODE-DAMPERS/DUCTS/SPRINKLERS/WALL EXT/DOOR	2010	45,802	1,665	27.5	1,665		11,031	2
3	BATHROOM TUB/TILES/FIXTURES/PAINTING	2010	18,773	683	27.5	683		4,468	3
4	BUILT-IN WARDROBES/CABINETS/DOORS/COUNTERTOP	2010	37,056	1,347	27.5	1,347		8,812	4
5	TREES/SHRUBS/PERENNIALS/HARDSCAPE/EPOXY STONE	2010	24,949	1,664	15	1,664		10,814	5
6	SUMP PUMPS & CONTROL PANEL	2010	12,061	439	27.5	439		2,872	6
7	WALLPAPER/PAINTING/CARPETING/DRAPERIES/CURTAINS	2010	84,560	4,871	7	12,080	7,209	78,520	7
8	LIGHT FIXTURES/CIRCUIT PANEL	2010	3,682	134	27.5	134		865	8
9	30 HP COMPRESSOR	2010	15,835	575	27.5	576	1	3,719	9
10	PAINTING/CARPETING/TILE/COVE BASE/DRAPERIES	2010	22,385	1,289	7	3,198	1,909	20,787	10
11	OUTSIDE BRICKWORK&WINDOW TRIM/CAULK/TUCKPOINT	2011	11,000	400	27.5	400		2,083	11
12	FIRE DAMPERS	2011	13,620	495	27.5	495		2,537	12
13	CLOSET PROJECT-CARPENTRY/DOORS/ACCESS PANELS	2011	11,094	403	27.5	403		2,065	13
14	PAINTING / 3RD FL DININGROOM CARPENTRY / CHAIR RAILS / WALLPAPER / VINYL FLOORING & GLUE-DOWN CARPETING / WINDOW TREATMENTS / WOOD BLINDS								14
15		2011	22,202	2,558	7	3,172	614	17,446	15
16	3 BOILERS HEATING & 2 BOILERS WATER	2011	126,330	4,593	27.5	4,593		22,775	16
17	BOILER RM/ 3RD FL CLOSET PROJECT/ 2ND FL LIVINGROOM,CAFETERIA,DININGRM-CONCRETE/DRYWALL/CARPENTRY/WALL PREP/PAINTING/WALLPAPER/CHAIRRAILS								17
18	/FLOORING/TILES/COVE BASE/WINDOW TREATMENTS	2012	24,987	909	27.5	909		4,053	18
19	EAST ELEVATOR JACK/CYLINDER/VALVES/GUIDE SHOE	2012	40,708	1,480	27.5	1,480		6,475	19
20	COMPRESSOR PARTS/PIPING/FIRE DAMPERS	2012	9,490	345	27.5	345		1,268	20
21	INTERCOM CALL SYSTEM-WIRING,LIGHTS,BOX	2013	6,547	238	27.5	238		874	21
22	DEMOLITION/CONSTRUCTION-ENLARGE LOUNGE AREA	2013	7,103	258	27.5	258		933	22
23	DRILL TAP & 6 PUMP VALVES FOR COMPRESSOR SYSTEM	2013	8,820	321	27.5	321		1,085	23
24	KITCHEN,DISHWASHING AREAS - FLOORING/TILE/COVE BASE/THINSET/GROUT; LAUNDRY AREAS, RESIDENT ROOMS - DRYWALL/WALL PREP/PRIME/PAINT								24
25	/CARPENTRY/TRIM/STAIN per audit -2189	2013	20,092	810	27.5	810		2,645	25
26	EXTERIOR BRICKWORK/TUCKPOINTING/BLACK TOP	2013	12,722	463	27.5	463		1,484	26
27	ELEVATOR INFRARED -BEAMED SAFETY EDGE	2014	3,950	144	27.5	144		378	27
28	BUILT-IN STOVE HOOD	2014	4,000	145	27.5	145		345	28
29	LEVEL 2ND FL DININGROOM CEMENT FLOOR	2015	2,767	101	27.5	101		122	29
30	INSTALL CONCRETE PAD FOR NEW GENERATOR	2015	8,000	291	27.5	291		327	30
31	INSTALL 4"GAS LINE, VALVES FOR NEW GENERATOR	2015	8,325	303	27.5	303		316	31
32	85KW GAS GENERATOR,DESIGN FEE,2"GAS LINE,FENCE	2016	112,884	3,250	27.5	3,250		3,250	32
33	REPLACE CYLINDER ON WEST PASSENGER ELEVATOR	2016	38,900	884	27.5	884		884	33
34	TOTAL (lines 1 thru 33)		$ 4,224,416	$ 64,176		$ 128,134	$ 63,958	$ 2,942,317	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: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12B, Carried Forward		$ 4,224,416	$ 64,176		$ 128,134	$ 63,958	$ 2,942,317	1
2	NEW FLAT ROOF COATING	2016	4,974	98	27.5	98		98	2
3	VINYL TILE/COVE BASE-RESIDENT ROOMS 104/106/127	2016	9,952	136	27.5	136		136	3
4	INSTALL 12 OUTLETS & 2 FUSE BOXES	2016	21,000	96	27.5	96		96	4
5	WEST ELEVATOR VALVE	2016	6,250	10	27.5	10		10	5
6									6
7									7
8	ADJUST TO SL			63,958			(63,958)		8
9									9
10									10
11	ADJUST TO BALANCE SHEET								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	TOTAL (lines 1 thru 33)		$ 4,266,592	$ 128,474		$ 128,474	$	$ 2,942,657	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: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 176,731	$ 15,969	$ 15,969	$	8-15 yrs	$ 111,884	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 176,731	$ 15,969	$ 15,969	$		$ 111,884	75

D. Vehicle Costs. (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	$ 1,775	$	$ (1,775)	4 YRS	$ 44,566	76
77	ADMINISTRATIVE,ETC									77
78										78
79	FACILITY VAN		1998	13,600				4 YRS	13,600	79
80	TOTALS			$ 58,166	$ 1,775	$	$ (1,775)		$ 58,166	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)	$ 4,612,139	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 146,218	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 144,443	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,775)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,112,707	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: 01/01/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 0 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			$	$ 0	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: 01/01/2016 Ending: 12/31/2016

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.

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	$		$ 208,727	$		$ 208,727	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			45,322			45,322	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			467,221			467,221	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				158,220		158,220	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): SUPPLIES/LABS	39-2					13,906		13,906	12
13	Other (specify): RADIOLOGY	39-2					3,117		3,117	13
14	TOTAL			$		$ 721,270	$ 175,243		$ 896,513	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BIRCHWOOD PLAZA **#** 0028696 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 511,937	$ 516,949	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,176,668	3,176,668	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	156,183	156,183	6
7	Other Prepaid Expenses	110,716	110,716	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM OTHERS	92,966	902,966	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,048,470	$ 4,863,482	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		2,143,681	15
16	Equipment, at Historical Cost	44,566	234,897	16
17	Accumulated Depreciation (book methods)	(27,485)	(3,459,974)	17
18	Deferred Charges		5,820	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 REPLACEMENT RESERVE		3,353,624	22
23	Other(specify): NY LIFE INSUR.CONTRACTS	203,304	203,304	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 220,385	$ 4,794,518	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,268,855	$ 9,658,000	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 766,423	$ 766,423	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		7,928,997	29
30	Accrued Salaries Payable	89,136	89,136	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,096	9,096	31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,000	254,850	32
33	Accrued Interest Payable		11,322	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO BIRCHWD PLAZA ASSOC	1,162,789		36
37	DUE TO CDS LLC	15,000	15,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,060,444	$ 9,074,824	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	505,143	505,143	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 505,143	$ 505,143	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,565,587	$ 9,579,967	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,703,268	$ 78,033	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,268,855	$ 9,658,000	48

***(See instructions.)**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,356,267	1	
2	Restatements (describe):		2	
3	2015 IL REPLACEMENT TAX	(31,778)	3	
4	ROUNDING	3	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,324,492	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,308,776	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	(1,930,000)	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)**	$ (621,224)	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)**	$ 1,703,268	24	*

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,461,414	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,461,414	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	217,827	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 217,827	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	343	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)**	$ 343	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,240	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,240	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)**	$ 11,681,824	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,417,020	31
32	Health Care	3,324,121	32
33	General Administration	3,110,240	33
	B. Capital Expense		
34	Ownership	1,180,195	34
	C. Ancillary Expense		
35	Special Cost Centers	896,513	35
36	Provider Participation Fee	444,959	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,373,048	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,308,776	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,308,776	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,421,461	44
45	Private Pay - Net Inpatient Revenue	2,364,949	45
46	Medicare - Net Inpatient Revenue	2,411,984	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	263,020	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,461,414	49

* **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: 01/01/2016 Ending: 12/31/2016

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	2,800	2,908	$ 126,249	$ 43.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,685	38,173	1,171,420	30.69	3
4	Licensed Practical Nurses	6,687	7,265	194,911	26.83	4
5	CNAs & Orderlies	90,602	97,111	1,147,598	11.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,199	2,411	54,975	22.80	9
10	Activity Assistants	12,264	12,772	151,726	11.88	10
11	Social Service Workers	3,155	3,283	101,848	31.02	11
12	Dietician					12
13	Food Service Supervisor	216	216	8,308	38.46	13
14	Head Cook	2,060	2,270	55,330	24.37	14
15	Cook Helpers/Assistants	2,027	2,287	33,070	14.46	15
16	Dishwashers	15,946	17,149	182,407	10.64	16
17	Maintenance Workers	4,195	4,536	95,114	20.97	17
18	Housekeepers	18,404	20,155	241,492	11.98	18
19	Laundry	5,692	6,287	76,019	12.09	19
20	Administrator	2,102	2,102	247,584	117.78	20
21	Assistant Administrator	2,097	2,097	63,526	30.29	21
22	Other Administrative	1,425	1,425	52,666	36.96	22
23	Office Manager	5,230	5,658	174,927	30.92	23
24	Clerical	2,839	2,931	31,897	10.88	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	1,692	1,852	66,383	35.84	31
32	Other Health C: Rehab Director	1,180	1,300	58,008	44.62	32
33	Other(specify) Marketing	1,642	1,642	36,005	21.93	33
34	TOTAL (lines 1 - 33)	220,139	235,830	$ 4,371,463 *	$ 18.54	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	$ 9,828	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	4,800	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,670	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	1,200	11-3	44
45	Social Service Consultant	E	2,625	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 34,123		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ABRAHAM SCHIFFMAN	ADMINISTRATOR		$ 247,584
JOYCE GRODETZ	ASST ADMIN		63,526
REBECCA KOHN	OTHER ADMIN		52,666
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 363,776

B. Administrative - Other

Description		Amount
CHARLOTTE KOHN	MANAGEMENT FEES	$ 90,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 90,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 7,342
MATRIX MDI ACHIEVE	DATA PROCESSING	43,452
KRUPNICK BOKOR	ACCOUNTING	20,300
MYRON TUSHBAI	ACCOUNTING	21,225
RICHARD PEELO	MEDICARE COST REPORT	3,250
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULT	857
ADVANTAGE BENEFITS	501A PLAN CONSULTANT	2,286
LEGAL	SEE SCHEDULE	12,569
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 111,281

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 137,789
Unemployment Compensation Insurance		18,543
FICA Taxes		319,408
Employee Health Insurance		399,146
Employee Meals		28,324
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		52
EMPLOYEE PHYSICAL EXAMS		490
PENSION/PROFIT SHARING PLANS (CVA)		34,764
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 938,516

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	$ 1,990
Advertising: Employee Recruitment	29,085
Health Care Worker Background Check	880
(Indicate # of checks performed 45)	
Patient Background Checks 31	310
TRUST/FRANCHISE/CONTRIB/ETC	3,750
MARKETING/ADV/PROMO	56,001
LICENSES/DUES/SUBSCRIPTIONS	3,799
TRUST/FRANCHISE/CONTRIB/ETC	(3,750)
Less: Public Relations Expense	(0)
Non-allowable advertising	(17,275)
Yellow page advertising	(38,726)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,064

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	2,456
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,456

* Attach copy of IMRF notifications

**See instructions.

BIRCHWOOD PLAZA
SCHEDULE-LEGAL
12/31/2016

PROFESSIONAL FEES - LEGAL					TOTAL
DATE	**FIRM**	**INVOICE #**	**PURPOSE**	**COST**	**COST**
3.16	RIEFF SCHRAMM KANTER GUTTMAN	3235	REAL ESTATE TAX ABATEMENT - FILING FEE	225.00	
5.16	RIEFF SCHRAMM KANTER GUTTMAN		2015 ILLEGAL REAL ESTATE TAX RATE REFUND	7,732.93	
					7,957.93
2.16	STONE POGRUND KOREY	64700	LEGAL GUARDIANSHIP ISSUES	75.00	
5.16	STONE POGRUND KOREY	68095	LEGAL GUARDIANSHIP ISSUES	150.00	
6.16	STONE POGRUND KOREY	68937	LEGAL GUARDIANSHIP ISSUES	411.50	
7.16	STONE POGRUND KOREY	70035	LEGAL GUARDIANSHIP ISSUES	714.29	
8.16	STONE POGRUND KOREY	71465	LEGAL GUARDIANSHIP ISSUES	475.00	
9.16	STONE POGRUND KOREY	72550	LEGAL GUARDIANSHIP ISSUES	25.00	
10.16	STONE POGRUND KOREY	73561	LEGAL GUARDIANSHIP ISSUES	350.00	
11.16	STONE POGRUND KOREY	74271	LEGAL GUARDIANSHIP ISSUES	1,375.00	
12.16	STONE POGRUND KOREY	75060	LEGAL GUARDIANSHIP ISSUES	1,035.50	
					4,611.29
				TOTAL	**12,569.22**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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? **NO**
If YES, give association name and amount.

(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. $ **66,927** 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. $ **444,959**
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. $ **28,324** 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees