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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 01/01/2017 to 12/31/2017 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) _____ (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: 01/01/2017 Ending: 12/31/2017

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			4,532	4,532	8
9	SNF/PED					9
10	ICF	44,074	10,136	1,593	55,803	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,074	10,136	6,125	60,335	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.65%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 4,532

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	297,358	32,372	10,488	340,218		340,218	0	340,218			1
2	Food Purchase		395,272		395,272	(29,346)	365,926	(2,008)	363,918			2
3	Housekeeping	245,338	64,542	0	309,880		309,880	0	309,880			3
4	Laundry	85,123	16,250	6,406	107,779		107,779	0	107,779			4
5	Heat and Other Utilities			163,024	163,024		163,024	0	163,024			5
6	Maintenance	102,904	24,291	48,853	176,048		176,048	0	176,048			6
7	Other (specify):*			6,164	6,164		6,164	0	6,164			7
8	**TOTAL General Services**	730,723	532,727	234,935	1,498,385	(29,346)	1,469,039	(2,008)	1,467,031			8
	B. Health Care and Programs											
9	Medical Director	0		6,000	6,000		6,000	0	6,000			9
10	Nursing and Medical Records	2,944,713	214,490	14,610	3,173,813		3,173,813	0	3,173,813			10
10a	Therapy	131,652		25	131,677		131,677	0	131,677			10a
11	Activities	224,556	8,457	4,165	237,178		237,178	0	237,178			11
12	Social Services	111,896		2,400	114,296		114,296	0	114,296			12
13	CNA Training			0	0		0	0	0			13
14	Program Transportation			528	528		528	0	528			14
15	Other (specify):*	0			0		0	0	0			15
16	**TOTAL Health Care and Programs**	3,412,817	222,947	27,728	3,663,492	0	3,663,492	0	3,663,492			16
	C. General Administration											
17	Administrative	348,917		1,169,100	1,518,017		1,518,017	(1,079,100)	438,917			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			105,315	105,315		105,315	(1,195)	104,120			19
20	Dues, Fees, Subscriptions & Promotions			83,411	83,411		83,411	(65,299)	18,112			20
21	Clerical & General Office Expenses	197,762	26,754	34,145	258,661		258,661	0	258,661			21
22	Employee Benefits & Payroll Taxes			944,733	944,733	29,346	974,079	0	974,079			22
23	Inservice Training & Education			0	0		0	0	0			23
24	Travel and Seminar			3,986	3,986		3,986	0	3,986			24
25	Other Admin. Staff Transportation			7,789	7,789		7,789	0	7,789			25
26	Insurance-Prop.Liab.Malpractice			192,005	192,005		192,005	0	192,005			26
27	Other (specify):* QA	27,242		197,891	225,133		225,133	(197,891)	27,242			27
28	**TOTAL General Administration**	573,921	26,754	2,738,375	3,339,050	29,346	3,368,396	(1,343,485)	2,024,911			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,717,461	782,428	3,001,038	8,500,927	0	8,500,927	(1,345,493)	7,155,434			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: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,488	
	REPAIRS & MAINTENANCE		0	
				10,488
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		6,406	
				6,406
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		41,473	
	ELECTRICITY		62,458	
	WATER		50,880	
	CABLE TV - LOBBY		8,213	
				163,024
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,417	
	PAINTING & DECORATING		1,024	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		3,250	
	EQUIPMENT MAINTENANCE & REPAIR		15,435	
	ELEVATOR MAINTENANCE & REPAIR		10,005	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		6,510	
	FIRE SERVICE		7,212	
				48,853
7	**OTHER**			
	SCAVENGER		6,164	
	SECURITY SERVICE		0	
				6,164
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		360	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,400	
	PHARMACY CONSULTANT	XVIII B 39-2	9,850	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				14,610
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		25	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				25
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,200	
	CLERGY		2,965	4,165
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,400	
				2,400
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number BIRCHWOOD PLAZA **#0028696** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		528	
				528
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	1,169,100	1,169,100
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	47,117	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	58,198	
				105,315
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	25,893	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	12,060	
	CONTRIBUTIONS	VI 20 XIX F	2,130	
	DUES & SUBSCRIPTIONS	XIX F	367	
	LICENSES & PERMITS	XIX F	4,545	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	37,176	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	100	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	580	
	PATIENT BACKGROUND CHECKS	XIX F	560	
				83,411
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,498	
	EQUIPMENT REPAIR & MAINTENANCE		14,070	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,577	
	MESSENGER SERVICE		0	
				34,145

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	364,126	
	UNEMPLOYMENT COMPENSATION	XIX D	0	
	WORKERS COMPENSATION INSURANC	XIX D	119,776	
	HOSPITALIZATION INSURANCE	XIX D	426,232	
	EMPLOYEE BENEFITS - OTHER	XIX D	3	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	32,305	
	501 PLAN - CASH VALUE ADJ	XIX D	2,291	
				944,733
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,986	
	TRAVEL	XIX G	0	
				3,986
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,538	
	AUTO EXPENSE - OTHER		251	7,789
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		192,005	
				192,005
27	**OTHER**			
	BAD DEBTS	VI 24	197,891	
				197,891

GRAND TOTAL COLUMN 3 OTHER **3,001,038**

BIRCHWOOD PLAZA
SCHEDULES
12/31/2017

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

TOTAL FOOD PURCHASE	395,272
LESS SALES TAX	(2,008)
NET FOOD	393,264
TOTAL PATIENT CENSUS	60,335
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	181,005
ADD # EMPLOYEE MEALS/DAY	40
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	14,600
PATIENT MEALS	181,005
ADD EMPLOYEE MEALS	14,600
TOTAL MEALS/YEAR	195,605
NET FOOD	393,264
DIVIDE TOTAL MEALS/YEAR	195,605
COST PER MEAL	2.01
TIMES EMPLOYEE MEALS	14,600
EMPLOYEE MEAL RECLASSIFICATION	**29,346**

Facility Name & ID Number BIRCHWOOD PLAZA #0028696 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			1,775	1,775		1,775	133,458	135,233			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			4,980	4,980		4,980	253,342	258,322			32
33	Real Estate Taxes			299,490	299,490		299,490	0	299,490			33
34	Rent-Facility & Grounds			936,000	936,000		936,000	(936,000)	0			34
35	Rent-Equipment & Vehicles			0	0		0	0	0			35
36	Other (specify):* STORAGE			4,702	4,702		4,702	0	4,702			36
37	TOTAL Ownership			1,246,947	1,246,947	0	1,246,947	(549,200)	697,747			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		162,671	518,016	680,687		680,687	0	680,687			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			455,374	455,374		455,374	0	455,374			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	162,671	973,390	1,136,061	0	1,136,061	0	1,136,061			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,717,461	945,099	5,221,375	10,883,935	0	10,883,935	(1,894,693)	8,989,242			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: 01/01/2017 Ending: 12/31/2017

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	(28,960)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,008)	2		13
14	Non-Care Related Interest	0	32		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				18
19	Entertainment				19
20	Contributions	(2,130)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,195)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(197,891)	27		24
25	Fund Raising, Advertising and Promotional	(25,893)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(37,176)	20		28
29	Other-Attach Schedule SEE PG 5A	(1,079,100)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,376,228)		$ 0	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)	(518,465)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (518,465)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,894,693)		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: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DISALLOWED EXCESS MANAGEMENT FEE	$ (1,079,100)	17	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				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**	(1,079,100)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD PLAZA **#** 0028696 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,008)	0	0	0	0	0	0	0	0	0	0	(2,008)	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**	(2,008)	0	0	0	0	0	0	0	0	0	0	(2,008)	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	(1,079,100)	0	0	0	0	0	0	0	0	0	0	(1,079,100)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,195)	0	0	0	0	0	0	0	0	0	0	(1,195)	19
20	Fees, Subscriptions & Promotions	(65,299)	0	0	0	0	0	0	0	0	0	0	(65,299)	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):*	(197,891)	0	0	0	0	0	0	0	0	0	0	(197,891)	27
28	**TOTAL General Administration**	(1,343,485)	0	0	0	0	0	0	0	0	0	0	(1,343,485)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,345,493)	0	0	0	0	0	0	0	0	0	0	(1,345,493)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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)	135,233	0	0	0	0	0	0	0	0	0	133,458	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,960)	282,302	0	0	0	0	0	0	0	0	0	253,342	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	(30,735)	(518,465)	0	0	0	0	0	0	0	0	0	(549,200)	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)	(1,376,228)	(518,465)	0	0	0	0	0	0	0	0	0	(1,894,693)	45

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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
						PARKING LOT
				CDS LLC	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		" "		135,233	135,233	4
5	V	32	INTEREST		" "		282,302	282,302	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			$ 417,535	$ * (518,465)	14

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	11,153	6-1	2
3	CYNTHIA KOHN	OFFICE MGR	OFFICE MGR	0.00	0	20	100.00	SALARY	57,143	23-1	3
4	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	58,666	6	50.00	SALARY	52,533	17-1	4
5											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	$ 210,829		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: 01/01/2017 Ending: 2/31/2017

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: 01/01/2017 Ending: 12/31/2017

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - BIRCHWOOD PLAZA ASSOCIATES: MORTGAGE						$	$			$	1
2	CIBC BANK		X	MORTGAGE	$16,667+INT	3/14/2012	9,000,000	7,756,607	3/14/2017	5.2500	268,986	2
3	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS			44,974	37,478			13,316	3
4												4
5												5
	Working Capital											
6	CIBC BANK		X	LINE OF CREDIT							4,980	6
7												7
8												8
9	TOTAL Facility Related						$ 9,044,974	$ 7,794,085			$ 287,282	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 9,044,974	$ 7,794,085			$ 287,282	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:** 01/01/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	254,850	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.)	$	275,790	2
3. Under or (over) accrual (line 2 minus line 1).	$	20,940	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	278,550	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.	$	299,490	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	239,745	8
	2013	242,990	9
	2014	247,884	10
	2015	252,323	11
	2016	275,790	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 2016 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-302-011-0000	NURSING HOME	$ 4,134.17	$ 4,134.17
2.	11-29-302-012-0000	NURSING HOME	$ 112,005.45	$ 112,005.45
3.	11-29-302-020-0000	NURSING HOME	$ 140,175.04	$ 140,175.04
4.	11-29-302-016-0000	PARKING LOT	$ 7,673.09	$ 7,673.09
5.	11-29-302-017-0000	PARKING LOT	$ 5,963.22	$ 5,963.22
6.	11-29-302-018-0000	PARKING LOT	$ 5,839.39	$ 5,839.39
7.			$	$ 0.00
8.			$	$ 0.00
9.			$	$ 0.00
10.			$	$ 0.00
		TOTALS	$ 275,790.36	$ 275,790.36

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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	1,912,896	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	2,094	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	15,327	14
15	NURSING STATION REMODELLING	per audit -7,755		1985	0		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	0		20				22
23	VARIOUS (ELECTRIC & SPRINKLER)			1986	5,486		20			5,486	23
24	ELECTRIC PANEL			1988	6,000		20			6,000	24
25	ELECTRICAL IMPROVEMENTS			1990	1,200		20			1,200	25
26	ELEVATOR IMPROVEMENTS			1990	15,600		20			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	0	149	39		(149)		32
33	WINDOWS			1998	41,775	615	25	1,671	1,056	33,420	33
34	SIDING			1998	20,000	513	25	800	287	16,000	34
35	PATIENT ROOM EXHAUST SYSTEM			1998	9,720	486	20	486		9,439	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: 01/01/2017 Ending: 12/31/2017

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	$ 2,499	$ 2,499	$ 49,866	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		27,916	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		12,932	39
40	CARPETING / DRAPERIES	2000	5,062		7			5,062	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		4,106	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		3,125	42
43	ELEV UPGRADE/FRONT OUTDooR WALL SYST per audit -1,016	2001	88,201	3,244	27.5	3,244		53,932	43
44	CARPETING	2001	8,264		7			8,264	44
45	DRAPERIES per audit -7,753	2001	0		7				45
46	WALLPAPER / CARPETING per audit -18,309	2002	0		7			0	46
47	NURSES STATION	2002	15,101	549	27.5	549		8,349	47
48	WALLPAPER / ELEVATOR UPGRADE per audit -13,835	2003	0	503	27.5	503		7,429	48
49	WALLPAPER / CARPENTRY	2004	46,774	1,701	27.5	1,701		22,392	49
50	WALLPAPER / CARPENTRY / REMODELING	2005	18,014	655	27.5	655		8,176	50
51	CIRCULATING PUMP	2005	4,139	150	27.5	150		1,864	51
52	PHONE SYST/WALLPAPER/FLOOR/CARPENTRY/REMODELING	2006	13,703	498	27.5	498		5,935	52
53	FIRE SUPPRESSION SYST/LIGHT FIXTURES	2006	5,719	208	27.5	208		2,418	53
54	ELEV DOOR RESTRICTOR/PUMP/SENSORS	2006	6,784	247	27.5	247		2,851	54
55	GREASE TRAP/PLUMBING/CONCRETE/THRU-WALL A/C'S	2006	12,014	437	27.5	437		5,007	55
56	NURSING STATION/KITCHEN TILE	2006	14,907	542	27.5	542		6,087	56
57	NURSING STATION/FLOORING/LIGHTING/THRU-WALL A/C'S	2007	11,968	435	27.5	435		4,706	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		2,005	59
60	LL OFFICE/BATHRMS/TILE/LOCKS/WIRING/THRU-WALL A/C	2008	45,488	1,654	27.5	1,654		15,600	60
61	CARPETING per audit -2,030	2008	0		7				61
62	ROOF	2009	68,700	2,498	27.5	2,498		20,713	62
63	SECURITY SYST/WIRING/CABLE/OUTLETS per audit -7,500	2009	49,737	2,082	27.5	2,082		17,079	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		7,171	65
66	CARPENTRY/BUILT-INS/MOLDING/TILE/ELECTRIC/CEILING	2009	14,653	533	27.5	533		4,287	66
67	PAINTING/WALLCOVERING/CARPETING	2009	70,916		7			70,916	67
68	MIRRORS/CEILING/LIGHT FIXTURES/RAILS/BUMPERS	2010	13,883	505	27.5	505		4,019	68
69	ELEVATOR MOTOR/STARTER	2010	5,680	207	27.5	207		1,647	69
70	TOTAL (lines 4 thru 69)		$ 3,465,772	$ 32,280		$ 82,284	$ 50,361	$ 2,811,368	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: 01/01/2017 Ending: 12/31/2017

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	$ 32,280		$ 82,284	$ 50,004	$ 2,811,368	1
2	FIRE CODE-DAMPERS/DUCTS/SPRINKLERS/WALL EXT/DOOR	2010	45,802	1,665	27.5	1,665		12,696	2
3	BATHROOM TUB/TILES/FIXTURES/PAINTING	2010	18,773	683	27.5	683		5,151	3
4	BUILT-IN WARDROBES/CABINETS/DOORS/COUNTERTOP	2010	37,056	1,347	27.5	1,347		10,159	4
5	TREES/SHRUBS/PERENNIALS/HARDSCAPE/EPOXY STONE	2010	24,949	1,664	15	1,664		12,478	5
6	SUMP PUMPS & CONTROL PANEL	2010	12,061	439	27.5	439		3,311	6
7	WALLPAPER/PAINTING/CARPETING/DRAPERIES/CURTAINS	2010	84,560	4,871	7	6,040	1,169	84,560	7
8	LIGHT FIXTURES/CIRCUIT PANEL	2010	3,682	134	27.5	134		999	8
9	30 HP COMPRESSOR	2010	15,835	575	27.5	576	1	4,295	9
10	PAINTING/CARPETING/TILE/COVE BASE/DRAPERIES	2010	22,385	1,289	7	1,598	309	22,385	10
11	OUTSIDE BRICKWORK&WINDOW TRIM/CAULK/TUCKPOINT	2011	11,000	400	27.5	400		2,483	11
12	FIRE DAMPERS	2011	13,620	495	27.5	495		3,032	12
13	CLOSET PROJECT-CARPENTRY/DOORS/ACCESS PANELS	2011	11,094	403	27.5	403		2,468	13
14	PAINTING / 3RD FL DININGROOM CARPENTRY / CHAIR RAILS / WALLPAPER / VINYL FLOORING & GLUE-DOWN CARPETING / WINDOW TREATMENTS								14
15		2011	22,202	2,558	7	3,172	614	20,618	15
16	3 BOILERS HEATING & 2 BOILERS WATER	2011	126,330	4,593	27.5	4,593		27,368	16
17	BOILER RM/ 3RD FL CLOSET PROJECT/ 2ND FL LIVINGROOM,CAFETERIA,DININGRM-CONCRETE/DRYWALL/CARPENTRY/WALL PREP/PAINTING/WA								17
18	/FLOORING/TILES/COVE BASE/WINDOW TREATMENTS	2012	24,987	909	27.5	909		4,962	18
19	EAST ELEVATOR JACK/CYLINDER/VALVES/GUIDE SHOE	2012	40,708	1,480	27.5	1,480		7,955	19
20	COMPRESSOR PARTS/PIPING/FIRE DAMPERS	2012	9,490	345	27.5	345		1,613	20
21	Intercom call system-wiring, lights, box throughout building	2013	6,547	238	27.5	238		1,112	21
22	Demolition & re-construction 1st & 2nd fl to enlarge lounge area	2013	7,103	258	27.5	258		1,191	22
23	Drill tap & 6 pump valves for compressor system	2013	8,820	321	27.5	321		1,406	23
24	Kitchen,dishwashing areas - flooring/tile/cove base/thinset/grout; laundry areas; resident rooms 111 & 307-drywall/wall prep/prime/paint								24
25	/carpentry/trim/stain per audit -2189	2013	20,092	810	27.5	810		3,455	25
26	Exterior brickwork/tuckpointing/blacktop	2013	12,722	463	27.5	463		1,947	26
27	Install infrared elevator beamed safety edge system	2014	3,950	144	27.5	144		522	27
28	Built-in kitchen stove hood	2014	4,000	145	27.5	145		490	28
29	Level 2nd floor diningroom cement floor	2015	2,767	101	27.5	101		223	29
30	Install concrete pad behind building for new generator	2015	8,000	291	27.5	291		618	30
31	Install 4"gas line & valves for new generator	2015	8,325	303	27.5	303		619	31
32	85KW gas generator, design fee,2" gas line, fence surround	2016	112,884	4,104	27.5	4,104		7,354	32
33	Replace cylinder on west passenger elevator	2016	38,900	1,414	27.5	1,414		2,298	33
34	TOTAL (lines 1 thru 33)		$ 4,224,416	$ 64,722		$ 116,819	$ 52,097	$ 3,059,136	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: 01/01/2017 Ending: 12/31/2017

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	$ 64,722		$ 116,819	$ 52,097	$ 3,059,136	1
2	New flat roof protective coating	2016	4,974	181	27.5	181		279	2
3	Replace vinyl tile & cove base in resident rooms 104/106/127	2016	9,952	362	27.5	362		498	3
4	Install 12 outlets & 2 fuse boxes	2016	21,000	764	27.5	764		860	4
5	Replace west elevator valve	2016	6,250	227	27.5	227		237	5
6	Electrical wiring for uprades to fire alarm system connections								6
7	to both elevators & generator	2017	9,775	163	27.5	163		163	7
8									8
9									9
10									10
11	ADJUST TO SL			52,097			(52,097)		11
12									12
13	CAPITAL COST REPORT AUDIT ADJUSTMENTS		109,686						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)		$ 4,386,053	$ 118,516		$ 118,516	$ 0	$ 3,061,173	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: 01/01/2017 Ending: 12/31/2017

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	$ 174,815	$ 14,563	$ 14,563	$ 0	8-15 yrs	$ 124,531	71
72	Current Year Purchases	18,947	2,154	2,154	0	8-10 yrs	2,154	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 193,762	$ 16,717	$ 16,717	$ 0		$ 126,685	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						0			77
78							0			78
79	FACILITY VAN		1998	13,600			0	4 YRS	13,600	79
80	TOTALS			$ 58,166	$ 1,775	$ 0	$ (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)	$ 4,748,631	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,008	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 135,233	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)	$ 3,246,024	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: 01/01/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: 01/01/2017 Ending: 12/31/2017

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	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

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	$		$ 135,881	$		$ 135,881	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			36,469			36,469	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			345,666			345,666	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				146,443		146,443	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): SUPPLIES/LABS	39-3					13,432		13,432	12
13	Other (specify): RADIOLOGY	39-2					2,796		2,796	13
14	TOTAL			$		$ 518,016	$ 162,671		$ 680,687	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: 01/01/2017 Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 497,339	$ 500,450	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,429,569	2,429,569	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	308,907	308,907	6
7	Other Prepaid Expenses	2,883	2,883	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM OTHERS	111,887	921,887	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,350,585	$ 4,163,696	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		2,153,456	15
16	Equipment, at Historical Cost	44,566	253,844	16
17	Accumulated Depreciation (book methods)	(29,260)	(3,533,398)	17
18	Deferred Charges		37,478	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): LIFE INSUR.CONTRACTS	201,013	201,013	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 216,319	$ 4,779,183	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,566,904	$ 8,942,879	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 611,622	$ 611,622	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,000	300,004	29
30	Accrued Salaries Payable	128,853	128,853	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,164	13,164	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,670	278,550	32
33	Accrued Interest Payable		18,278	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO BIRCHWD PLAZA ASSOC	1,547,003	0	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,420,312	$ 1,350,471	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,556,603	40
41	Bonds Payable			41
42	Deferred Compensation	463,437	463,437	42
	Other Long-Term Liabilities(specify):			
43	oob!!!			43
44	0			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 463,437	$ 8,020,040	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,883,749	$ 9,370,511	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 683,155	$ (427,632)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,566,904	$ 8,942,879	48

***(See instructions.)**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,703,268	1
2	Restatements (describe):		2
3	2016 IL REPLACEMENT TAX	(18,779)	3
4	ROUNDING	4	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,684,493	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,520,677	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	(2,522,015)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,001,338)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 683,155	24 *

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 11,953,874	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,953,874	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	417,821	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 417,821	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	3,957	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)**	$ 3,957	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,960	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,960	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)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,404,612	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,498,385	31
32	Health Care	3,663,492	32
33	General Administration	3,339,050	33
	B. Capital Expense		
34	Ownership	1,246,947	34
	C. Ancillary Expense		
35	Special Cost Centers	680,687	35
36	Provider Participation Fee	455,374	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,883,935	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,520,677	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,520,677	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,617,840	44
45	Private Pay - Net Inpatient Revenue	2,391,360	45
46	Medicare - Net Inpatient Revenue	2,593,233	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	351,441	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,953,874	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: 01/01/2017 Ending: 12/31/2017

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	1,989	2,161	$ 97,131	$ 44.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,860	39,383	1,231,839	31.28	3
4	Licensed Practical Nurses	6,714	7,501	200,175	26.69	4
5	CNAs & Orderlies	92,039	99,038	1,242,730	12.55	5
6	CNA Trainees					6
7	Licensed Therapist	2,344	2,344	112,960	48.19	7
8	Rehab/Therapy Aides	501	501	18,692	37.31	8
9	Activity Director	2,101	2,373	53,241	22.44	9
10	Activity Assistants	12,858	13,507	171,315	12.68	10
11	Social Service Workers	3,642	3,816	111,896	29.32	11
12	Dietician					12
13	Food Service Supervisor	433	433	16,656	38.47	13
14	Head Cook	2,091	2,308	57,980	25.12	14
15	Cook Helpers/Assistants	1,978	2,234	33,528	15.01	15
16	Dishwashers	15,310	16,466	189,194	11.49	16
17	Maintenance Workers	4,322	4,690	102,904	21.94	17
18	Housekeepers	17,385	19,188	245,338	12.79	18
19	Laundry	6,025	6,655	85,123	12.79	19
20	Administrator	2,085	2,085	232,017	111.28	20
21	Assistant Administrator	2,085	2,085	64,367	30.87	21
22	Other Administrative	1,664	1,664	52,533	31.57	22
23	Office Manager	5,298	5,545	178,400	32.17	23
24	Clerical	1,450	1,559	19,362	12.42	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	1,730	1,818	64,393	35.42	31
32	Other Health C: RN REHAB DIRE	2,180	2,451	108,445	44.25	32
33	Other(specify) QA	406	423	27,242	64.40	33
34	TOTAL (lines 1 - 33)	222,490	240,228	$ 4,717,461 *	$ 19.64	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	$ 10,488	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	4,400	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,850	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	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 31,938		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: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ABRAHAM SCHIFFMAN	ADMINISTRATOR		$ 232,017
JOYCE GRODETZ	ASST ADMIN		64,367
REBECCA KOHN	OTHER ADMIN		52,533
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 348,917

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	$ 7,286
MATRIX MDI ACHIEVE	DATA PROCESSING	39,831
KRUPNICK BOKOR	ACCOUNTING	27,800
MYRON TUSHBAI	ACCOUNTING	8,176
RICHARD PEELO	MEDICARE COST REPORT	3,790
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULT	1,253
ADVANTAGE BENEFITS	501A PLAN CONSULTANT	2,238
MICHAEL TODD GRENDON	PROFESSIONAL SERVICES	1,125
LEGAL	SEE SCHEDULE	13,816
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 105,315

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,776
Unemployment Compensation Insurance	20,297
FICA Taxes	343,829
Employee Health Insurance	426,232
Employee Meals	29,346
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	34,596
TOTAL (agree to Schedule V, line 22, col.8)	$ 974,079

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	$
Advertising: Employee Recruitment	12,060
Health Care Worker Background Check	580
(Indicate # of checks performed 5)	
Patient Background Checks 56	560
TRUST/FRANCHISE/CONTRIB/ETC	2,230
MARKETING/ADV/PROMO	63,069
LICENSES/DUES/SUBSCRIPTIONS	4,912
TRUST/FRANCHISE/CONTRIB/ETC	(2,230)
Less: Public Relations Expense	(0)
Non-allowable advertising	(25,893)
Yellow page advertising	(37,176)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,112

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	3,986
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,986

* Attach copy of IMRF notifications

**See instructions.

BIRCHWOOD PLAZA
Legal Fee Schedule
12/31/2017

PROFESSIONAL FEES - LEGAL					TOTAL
DATE	FIRM	INVOICE #	PURPOSE	COST	COST
1.17	RIEFF SCHRAMM KANTER GUTTMAN	13017	REAL ESTATE TAX ABATEMENT-FILING FEE	225.00	
1.17	RIGHEIMER MARTIN CINQUINO	16-1113	LEGAL GUARDIANSHIP ISSUES	2,187.50	
2.17	OTIS LAW GROUP LTD	00335	LEGAL GUARDIANSHIP ISSUES	1,265.00	
2.17	IRA SILVERSTEIN	1559-01M	LEGAL GUARDIANSHIP ISSUES	2,375.00	
10.17	SEGAL & SEGAL	MAR3-OCT23	LEGAL GUARDIANSHIP ISSUES	4,270.50	
1.17	STONE POGRUND KOREY	75942	LEGAL GUARDIANSHIP ISSUES	1,015.36	
2.17	STONE POGRUND KOREY	77784	LEGAL GUARDIANSHIP ISSUES	965.68	
3.17	STONE POGRUND KOREY	79531	LEGAL GUARDIANSHIP ISSUES	50.00	
4.17	STONE POGRUND KOREY	80118	LEGAL GUARDIANSHIP ISSUES	217.50	
7.17	STONE POGRUND KOREY	83198	LEGAL GUARDIANSHIP ISSUES	25.00	
8.17	STONE POGRUND KOREY	83982	LEGAL GUARDIANSHIP ISSUES	25.00	
6.17	CT LIEN SOLUTIONS		DISALLOWED ON COST REPORT	1,194.70	
				TOTAL	**13,816.24**
6.17	CT LIEN SOLUTIONS		Disallowed on Page 5 Section VI Line 22		(1,194.70)
				TOTAL	**12,621.54**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. $ **68,319** 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. $ **455,374**
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. $ **29,346** 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