FOR BHF USE							

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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
  - [ ] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code ______
- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [X] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other ______
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other ______

In the event there are further questions about this report, please contact:
Name: Mendel Schneider Telephone Number: (847)933-1274
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 01/01/2020 to 12/31/2020 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)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	See Accountant's Report Attached
	(Firm Name & Address)	Mendel S. Schneider C.P.A & Associates 4051 Old Orchard Rd. Skokie, Il 60712
	(Telephone)	(847)933-1274 Fax # (847)933-1283

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: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	32,529	3,707	3,777	40,013	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,529	3,707	3,777	40,013	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.66%

D. How many bed reserve days during this year were paid by the Department?
None (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 06/17/1984

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 06/17/1984 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 200 and days of care provided 3,777

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 Fiscal Year: 12/31

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	343,829	33,161	5,832	382,822		382,822		382,822			1
2	Food Purchase		304,241		304,241		304,241	(1,518)	302,723			2
3	Housekeeping	278,779	54,497	22,632	355,908		355,908		355,908			3
4	Laundry	116,911	7,600	5,617	130,128		130,128		130,128			4
5	Heat and Other Utilities			143,819	143,819		143,819		143,819			5
6	Maintenance	129,209		88,405	217,614		217,614		217,614			6
7	Other (specify):*											7
8	TOTAL General Services	868,728	399,499	266,305	1,534,532		1,534,532	(1,518)	1,533,014			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,449,101	252,925	88,264	3,790,290		3,790,290		3,790,290			10
10a	Therapy											10a
11	Activities	178,781	2,075		180,856		180,856		180,856			11
12	Social Services	65,964		1,740	67,704		67,704		67,704			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,693,846	255,000	96,004	4,044,850		4,044,850		4,044,850			16
	C. General Administration											
17	Administrative	227,584		909,212	1,136,796		1,136,796		1,136,796			17
18	Directors Fees											18
19	Professional Services			52,337	52,337		52,337		52,337			19
20	Dues, Fees, Subscriptions & Promotions			53,748	53,748		53,748	(49,891)	3,857			20
21	Clerical & General Office Expenses	396,252	39,700	78,928	514,880		514,880	14,189	529,069			21
22	Employee Benefits & Payroll Taxes			976,901	976,901		976,901		976,901			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,713	1,713		1,713		1,713			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			425,729	425,729		425,729		425,729			26
27	Other (specify):*											27
28	TOTAL General Administration	623,836	39,700	2,498,568	3,162,104		3,162,104	(35,702)	3,126,402			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,186,410	694,199	2,860,877	8,741,486		8,741,486	(37,220)	8,704,266			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (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	138,775	140,550			30
31	Amortization of Pre-Op. & Org.							8,995	8,995			31
32	Interest			4,027	4,027		4,027	156,282	160,309			32
33	Real Estate Taxes			332,553	332,553		332,553		332,553			33
34	Rent-Facility & Grounds			936,000	936,000		936,000	(936,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,274,355	1,274,355		1,274,355	(631,948)	642,407			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,981		127,981		127,981		127,981			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			330,232	330,232		330,232		330,232			42
43	Other (specify):* Bad Debt			57,993	57,993		57,993	(57,993)				43
44	TOTAL Special Cost Centers		127,981	388,225	516,206		516,206	(57,993)	458,213			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,186,410	822,180	4,523,457	10,532,047		10,532,047	(727,161)	9,804,886			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: 01/01/2020 Ending: 12/31/2020

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	42,071	30		9
10	Interest and Other Investment Income	(2,110)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,518)	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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,993)	43		24
25	Fund Raising, Advertising and Promotional	(49,966)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (69,516)		$	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)	(657,645)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (657,645)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (727,161)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BIRCHWOOD PLAZA

ID# 0028696

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(1,518)	0	0	0	0	0	0	0	0	0	0	(1,518)	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**	(1,518)	0	0	0	0	0	0	0	0	0	0	(1,518)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(49,966)	75	0	0	0	0	0	0	0	0	0	(49,891)	20
21	Clerical & General Office Expenses	0	14,189	0	0	0	0	0	0	0	0	0	14,189	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(49,966)	14,264	0	0	0	0	0	0	0	0	0	(35,702)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,484)	14,264	0	0	0	0	0	0	0	0	0	(37,220)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Capital Expense D. Ownership	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)	
30	Depreciation	42,071	96,704	0	0	0	0	0	0	0	0	0	138,775	30
31	Amortization of Pre-Op. & Org.	0	8,995	0	0	0	0	0	0	0	0	0	8,995	31
32	Interest	(2,110)	158,392	0	0	0	0	0	0	0	0	0	156,282	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	39,961	(671,909)	0	0	0	0	0	0	0	0	0	(631,948)	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):*	(57,993)	0	0	0	0	0	0	0	0	0	0	(57,993)	43
44	TOTAL Special Cost Centers	(57,993)	0	0	0	0	0	0	0	0	0	0	(57,993)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(69,516)	(657,645)	0	0	0	0	0	0	0	0	0	(727,161)	45

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Center LLC	Evanston	Birchwood Plaza Assoc	Chicago	Bldg rental
Charlotte Kohn Trust	25			CDS LLC	Chicago	Parking Lot 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	100.00%	$	$ (60,000)	1
2	V								2
3	V	34	RENT	876,000	BIRCHWOOD PLAZA ASSOCIATES	100.00%		(876,000)	3
4	V	32	Interest		BIRCHWOOD PLAZA ASSOCIATES		158,392	158,392	4
5	V	30	Depreciation		BIRCHWOOD PLAZA ASSOCIATES		96,704	96,704	5
6	V	31	Amortization		BIRCHWOOD PLAZA ASSOCIATES		8,995	8,995	6
7	V	20	License		BIRCHWOOD PLAZA ASSOCIATES		75	75	7
8	V	21	Office		BIRCHWOOD PLAZA ASSOCIATES		5,338	5,338	8
9	V	21	State Replacement Tax		BIRCHWOOD PLAZA ASSOCIATES		8,851	8,851	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 936,000			$ 278,355	$ * (657,645)	14

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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: 01/01/2020 Ending: 12/31/2020

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 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Charlotte Kohn	Executive director	Management	25.00	180,000	27	45.00	Mgmt Fees	$ 909,212	17-7	1
2	Rebecca Kohn	Admin Consultant	Consultant	0.00	56,400	12	50.00	Salary	53,400	21-1	2
3	Barak Kohn	Maintenance director	Maintenance	0.00	30,643	12	40.00	Salary	11,125	6-1	3
4	Cynthia Kohn	Bookkeeper	Bookkeeper	0.00	49,004	26	26.00	Salary	57,000	21-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 1,030,737		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: 01/01/2020 Ending: 2/31/2020

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]

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

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

	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: 01/01/2020 Ending: 12/31/2020

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	CIBC Bank		X	Mortgage	$16,667+INT	03/14/2017	$ 9,000,000	$ 6,240,371	03/14/22	5.2500	$ 158,392	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC Bank		X	Working Capital				100,000			4,027	6
7												7
8												8
9	TOTAL Facility Related						$ 9,000,000	$ 6,340,371			$ 162,419	9
	B. Non-Facility Related*											
10	Interest Income										(2,110)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,110)	14
15	TOTALS (line 9+line14)						$ 9,000,000	$ 6,340,371			$ 160,309	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: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	342,911	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.)	$	345,156	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,245	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	348,607	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.)**	$	(18,299)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	332,553	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	252,323	8
2016	275,790	9
2017	296,419	10
2018	339,351	11
2019	345,156	12

Accrual=345,156 x 1.01

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIRCHWOOD PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028696

CONTACT PERSON REGARDING THIS REPORT Mendel Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	11-29-302-011-0000	Nursing Home	$ 4,633.46	$ 4,633.46
2.	11-29-302-012-0000	Nursing Home	$ 141,986.98	$ 141,986.98
3.	11-29-302-020-0000	Nursing Home	$ 177,201.15	$ 177,201.15
4.	11-29-302-016-0000	Parking Lot	$ 8,373.83	$ 8,373.83
5.	11-29-302-017-0000	Parking Lot	$ 6,546.95	$ 6,546.95
6.	11-29-302-018-0000	Parking Lot	$ 6,413.14	$ 6,413.14
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 345,155.51	$ 345,155.51

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 01/01/2020 Ending: 12/31/2020

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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 44,974 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 8,995 4. Dates Incurred: 03/14/2017

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	B P ASSOCIATES-NURSING HOME		1984	$ 80,569	1
2	CDS LLC-Parking Lot		1997	30,081	2
3	TOTALS			$ 110,650	3

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	192		1984		$ 2,238,672	$	40	$ 55,967	$ 55,967	$ 2,080,797	4
5											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	2,280	11
12	TERRACE RESURFACE			1984	7,600		15			7,600	12
13	FOYER RE-FLOORING			1985	1,835		20			1,835	13
14	BASEMENT RENOVATION			1985	18,061		40	452	452	16,683	14
15	NURSING STATION REMODELING 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		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		20			12,300	27
28	LAUNDRY ROOM DUCTWORK			1990	3,000		20			3,000	28
29	BUILDING EXTENSION FOR OFFICE/ACT. ROOM/DR			1994	282,054		20			282,054	29
30	DRAPERY			1994	7,933		5			7,933	30
31	ROOF & PARKING LOT IMPROVEMENTS PER AUDIT 36,500			1995	33,484		15			33,484	31
32	ENLARGE PATIENT ROOMS(TRANS TO CI-C 97 AUDIT)			1997			39				32
33	WINDOWS			1998	41,775		25	1,671	1,671	38,433	33
34	SIDING			1998	20,000		25	800	800	18,400	34
35	PATIENT ROOM EXHAUST SYSTEM			1998	9,720		20	281	281	10,282	35
36	Elevator Safety Device			1998	5,350		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: 01/01/2020 Ending: 12/31/2020

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	$	$	$ 49,866	37
38	ROOFTOP A/C	1999	58,870		39	1,509	1,509	32,443	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264		39	699	699	15,029	39
40	CARPETING/DRAPERIES	2000	5,062		7			5,062	40
41	A/C SYSTEM	2000	6,395		27.5	233	233	4,805	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165		27.5	188	188	3,689	42
43	ELEV UPGRADE/FRONT OUTDOOR WALL SYST PER AUDIT	2001	88,201		27.5	3,244	3,244	63,664	43
44	CARPETING/DRAPERIES	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		27.5	549	549	9,996	47
48	WALLPAPER/ELEVATOR UPGRADE PER AUDIT 13,835	2003			27.5	503	503	8,435	48
49	WALLPAPER/CARPENTRY	2004	46,774		27.5	1,701	1,701	27,495	49
50	WALLPAPER/CARPENTRY/REMODELING	2005	18,014		27.5	655	655	10,141	50
51	CIRCULATING PUMP	2005	4,139		27.5	150	150	2,314	51
52	PHONE SYST/WALLPAPER/FLOOR/CARPETINTRY/REMODE	2006	13,703		27.5	498	498	7,429	52
53	FIRE SUPPRESSION SYST/LIGHT FIXTURES	2006	5,719		27.5	208	208	3,042	53
54	ELEV DOOR RESTRICTOR/PUMP/SENSORS	2006	6,784		27.5	247	247	3,592	54
55	GREASE TRAP/PLUMBING/CONCRETE/THRU WALL A/C	2006	12,014		27.5	437	437	6,318	55
56	NURSES STATION/KITCHEN TILE	2006	14,907		27.5	542	542	7,713	56
57	NURSING STATION/FLOORING/LIGHTING/THRU WALL AC	2007	11,968		27.5	435	435	6,011	57
58	FLOORING/CARPETING/WALLPAPER	2007	20,700		7			20,700	58
59	ACCOUSTICAL WALL TILE/FLOOR TILE	2007	5,315		27.5	193	193	2,584	59
60	LL OFFICE/BATHRMS/TILE/LOCKS/WIRING/THR WALL AC	2008	45,488		27.5	1,654	1,654	20,562	60
61	CARPETING PER AUDIT 2,030	2008			7				61
62	ROOF	2009	68,700		27.5	2,498	2,498	28,207	62
63	SECURITY SYST/WIRING/CABLE/OUTLETS PER AUDIT 7500	2009	49,737		27.5	2,082	2,082	23,325	63
64	TILE/DRYWALL/TOILETS/SINKS/LIGHT FIXTURES/PAITING/CARPENTRY/WINDOW FRAMES/FLOORING/COVE BASE/THR WALL A/CS								64
65		2009	24,135		27.5	877	877	9,802	65
66	CARPENTRY/BUILT INS/MOLDING/TILE/ELECTRIC/CEILIN	2009	14,653		27.5	533	533	5,886	66
67	PAINTING/WALLCOVERING/CARPETING	2009	70,916		7			70,916	67
68	MIRRORS/CEILING/LIGHT FIXTURES/RAILS/BUMPERS	2010	13,883		27.5	505	505	5,534	68
69	ELEVATOR MOTOR/STARTER	2010	5,680		27.5	207	207	2,268	69
70	TOTAL (lines 4 thru 69)		$ 3,465,772	$		$ 79,580	$ 79,580	$ 3,049,605	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: 01/01/2020 Ending: 12/31/2020

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	$		$ 79,580	$ 79,580	$ 3,049,605	1
2	FIRE CODE-DAMPERS/DUCTS/SPRINKLERS/WALL EXT/DO(	2010	45,802		27.5	1,665	1,665	17,691	2
3	BATHROOM TUB/TILES/FIXTURES/PAINTING	2010	18,773		27.5	683	683	7,200	3
4	BUILT-IN WARDROBES/CABINETS/DOORS/COUNTERTOP	2010	37,056		27.5	1,347	1,347	14,200	4
5	TREES/SHRUBS/PERENNIALS/HARDSCAPE/EPOXY STONE	2010	24,949		15	1,664	1,664	17,470	5
6	SUMP PUMP&CONTROL PANEL	2010	12,061		27.5	439	439	4,628	6
7	WALLPAPER/PAINTING/CARPETING/DRAPERIES/CURTAIN	2010	84,560		7			84,560	7
8	LIGHT FIXTURES/CIRCUIT PANEL	2010	3,682		27.5	134	134	1,401	8
9	30 HP COMPRESSOR	2010	15,835		27.5	575	575	6,021	9
10	PAINTING/CARPETING/TILE/COVE BASE/DRAPERIES	2010	22,385		7			22,385	10
11	OUTSIDE BRICKWORK&WINDOW TRIM/CAULK/TUCKPOII	2011	11,000		27.5	400	400	3,683	11
12	FIIRE DAMPERS	2011	13,620		27.5	495	495	4,517	12
13	CLOSET PROJECT-CARPENTRY/DOORS/ACCESS PANELS	2011	11,094		27.5	403	403	3,677	13
14	PAINTING/3RD FLR DINING ROOM CARPENTRY/CHAIR RAILS/WALLPAPER/VINYL FLOORING & GLUE DOWN CARPENTING/WINDOW TRE/								14
15		2011	22,202		7			22,202	15
16	3 BOILERS HEATING & 2 BOILERS WATER	2011	126,330		27.5	4,593	4,593	41,147	16
17	BOILER RM/ 3RD FL CLOSET PROJECT/2ND FL LIVING ROOM,CAFETERIA, DINING RM-CONCRETE/DRYWALL/CARPENTRY/WALL PREP/PA								17
18	FLOORING/TILES/COVE BASE/WINDOW TREATMENTS	2012	24,987		27.5	909	909	7,689	18
19	EAST ELEVATOR,JACK/CYLINDER/VALVES/GUIDE SHOE	2012	40,708		27.5	1,480	1,480	12,395	19
20	COMPRESSOR PARTS/PIPING/FIRE DAMPERS	2012	9,490		27.5	345	345	2,648	20
21	Intercom call system-wiring,lights,box throughout building	2013	6,547		27.5	238	238	1,826	21
22	Demolition & re constructruction 1st & 2nd floor to enlarge lounge	2013	7,103		27.5	258	258	1,965	22
23	drill tap & 6 pump valves for compressor system	2013	8,820		27.5	321	321	2,369	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		27.5	810	810	5,885	25
26	Exterior Brickwork/tuckpointing/blacktop	2013	12,722		27.5	463	463	3,336	26
27	Install Infrared elevator beamed safety system	2014	3,950		27.5	144	144	954	27
28	Built-in kitchen stove hood	2014	4,000		27.5	145	145	925	28
29	Level 2nd floor dining room cement floor	2015	2,767		27.5	101	101	526	29
30	Install concrete pad behind building for generator	2015	8,000		27.5	291	291	1,491	30
31	Install4" gas line & valves for new generator	2015	8,325		27.5	303	303	1,528	31
32	85kw gas generator,design fee,2" gas line, fence surround	2016	112,884		27.5	4,104	4,104	19,666	32
33	Replace cylinder on west passenger elevator	2016	38,900		27.5	1,414	1,414	6,540	33
34	TOTAL (lines 1 thru 33)		$ 4,224,416	$		$ 103,304	$ 103,304	$ 3,370,130	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: 01/01/2020 Ending: 12/31/2020

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	$		$ 103,304	$ 103,304	$ 3,370,130	1
2	New flat roof protective coating	2016	49,974		27.5	1,817	1,817	2,458	2
3	replace vinyl tile & cove base in resident rooms 104/106/127	2016	9,952		27.5	362	362	1,584	3
4	install 12 outlets & 2 fuse boxes	2016	21,000		27.5	764	764	3,152	4
5	replace west elevator valve	2016	6,250		27.5	227	227	918	5
6	Electrical wiring for upgrades to fire alarm system connections								6
7	to both elevators and generators	2017	9,775		27.5	355	355	1,228	7
8	Carpeting	2018	13,853		7	1,484	1,484	4,452	8
9	New Pump unit for east elevator	2018	7,500		27.5	272	272	646	9
10	16 electrical & lighting units	2018	5,200		27.5	189	189	417	10
11	19 improvements Hanna Z Interiors new flooring and drapery for I	2019	7,934		27.5	289	289	599	11
12	Install top layer of concrete on second floor outer dining room	2019	3,800		27.5	138	138	138	12
13	Installed 27 windows in resident rooms	2019	3,915		27.5	142	142	142	13
14	Elevator repairs -chicago elevator company, replaced detectors	2019	2,950		27.5	107	107	107	14
15	Roof Repairs on flat roof	2020	8,200		27.5	298	298	298	15
16									16
17									17
18									18
19	CAPITAL COST REPORT AUDIT ADJUSTMENT		109,686						19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28	Financial Statement Depreciation			98,479			(98,479)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,484,405	$ 98,479		$ 109,748	$ 11,269	$ 3,386,269	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: 01/01/2020 Ending: 12/31/2020

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	$ 281,739	$	$ 28,174	$ 28,174	10	$ 191,796	71
72	Current Year Purchases	26,276		2,628	2,628	10	2,628	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 308,015	$	$ 30,802	$ 30,802		$ 194,424	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	$	$	$	4	$ 44,566	76
77	administrative									77
78										78
79	Facility Van		1998	13,600				4	13,600	79
80	TOTALS			$ 58,166	$	$	$		$ 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)	$ 4,961,236	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 98,479	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 140,550	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 42,071	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,638,859	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: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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

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.	/2021	$
13.	/2022	$
14.	/2023	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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				100,225		100,225	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					27,756		27,756	12
13	Other (specify):									13
14	TOTAL			$		$	$ 127,981		$ 127,981	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: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 3,066,622	$ 3,145,851	1
2	Cash-Patient Deposits	228,532	228,532	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,284,551	1,284,551	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	284,155	284,155	6
7	Other Prepaid Expenses	25,451	25,451	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from related	1,019,633	1,829,633	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,908,944	$ 6,798,173	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		2,206,808	15
16	Equipment, at Historical Cost	44,566	368,094	16
17	Accumulated Depreciation (book methods)	(34,586)	(3,846,539)	17
18	Deferred Charges		10,868	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		2,543,333	22
23	Other(specify): Life Insurance Contracts	188,221	188,221	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 198,201	$ 3,783,951	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,107,145	$ 10,582,124	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 906,823	$ 915,784	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	228,532	228,532	28
29	Short-Term Notes Payable	1,217,900	1,217,900	29
30	Accrued Salaries Payable	165,734	165,734	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,177	13,177	31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,547	348,607	32
33	Accrued Interest Payable	302	13,042	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to related	2,699,997		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,254,012	$ 2,902,776	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,240,371	40
41	Bonds Payable			41
42	Deferred Compensation	473,237	473,237	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 473,237	$ 6,713,608	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,727,249	$ 9,616,384	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 379,896	$ 965,740	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,107,145	$ 10,582,124	48

*(See instructions.)

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 42,859	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 42,859	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	357,037	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	(20,000)	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)**	$ 337,037	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)**	$ 379,896	24 *

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 9,555,449	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,555,449	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,110	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,110	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Gov Stimulus Income	1,331,525	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,331,525	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,889,084	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,534,532	31
32	Health Care	4,044,850	32
33	General Administration	3,162,104	33
	B. Capital Expense		
34	Ownership	1,274,355	34
	C. Ancillary Expense		
35	Special Cost Centers	185,974	35
36	Provider Participation Fee	330,232	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,532,047	40
41	**Income before Income Taxes (line 30 minus line 40)****	357,037	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 357,037	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,686,403	44
45	Private Pay - Net Inpatient Revenue	938,587	45
46	Medicare - Net Inpatient Revenue	2,471,402	46
47	Other-(specify) Med b Income	459,057	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,555,449	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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,833	2,057	$ 95,689	$ 46.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,903	29,941	1,093,195	36.51	3
4	Licensed Practical Nurses	10,283	13,173	421,570	32.00	4
5	CNAs & Orderlies	66,652	79,064	1,314,766	16.63	5
6	CNA Trainees					6
7	Licensed Therapist	9,913	10,827	523,881	48.39	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,096	2,371	53,632	22.62	9
10	Activity Assistants	6,618	8,026	125,149	15.59	10
11	Social Service Workers	1,710	1,839	65,964	35.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,513	18,335	343,829	18.75	15
16	Dishwashers					16
17	Maintenance Workers	4,050	4,738	129,209	27.27	17
18	Housekeepers	13,805	16,806	278,779	16.59	18
19	Laundry	6,044	6,905	116,911	16.93	19
20	Administrator	2,080	2,080	227,584	109.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,226	13,429	396,252	29.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,726	209,591	$ 5,186,410 *	$ 24.75	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,832	1-3	35
36	Medical Director	Monthly	6,000	9-3	36
37	Medical Records Consultant	20	800	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,647	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	48	1,740	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	68	$ 21,019		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,296	$ 77,775	10-3	50
51	Licensed Practical Nurses	50	2,472	10-3	51
52	Certified Nurse Assistants/Aides	19	571	10-3	52
53	TOTAL (lines 50 - 52)	1,365	$ 80,818		53

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Abraham Schiffman	Administrative		$ 227,584
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 227,584

B. Administrative - Other

Description	Amount
Management Fee	$ 909,212
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 909,212

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider	Accounting	$ 18,000
Richard Peelo	Accounting	3,250
Myron Tushbai	Accounting	4,900
Clark Hill	Legal	3,000
Duane Morris	Legal	3,998
Monahan Law Group	Legal	1,980
Righeimer Martin & Cinquino	Legal	6,520
Personel Planners	Ui Tax Consultant	1,261
Advantage Benifets Solutions	Benifet Consultant	2,183
Korey Stone Pogrun	Legal	7,245
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 52,337

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,470
Unemployment Compensation Insurance	15,065
FICA Taxes	330,214
Employee Health Insurance	535,152
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 976,901

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	49,966
Health Care Worker Background Check	1,000
(Indicate # of checks performed)	
Patient Background Checks	867
Less: Public Relations Expense	( )
Non-allowable advertising	(49,966)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,857

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,713
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,713

**See instructions.

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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,000** Line **10**

(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. $ **330,232**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** 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? **100**
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? **No**
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) 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.