

Facility Name & ID Number BIRCHWOOD PLAZA

0028696 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	40,414	9,717	3,742	53,873	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,414	9,717	3,742	53,873	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.60%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 06/17/84

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/17/84 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 29 and days of care provided 2,566

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

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

Facility Name & ID Number **BIRCHWOOD PLAZA** # **0028696** Report Period Beginning: **01/01/2004** Ending: **12/31/2004**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	193,652	22,755	8,588	224,995		224,995		224,995		1
2	Food Purchase		213,794		213,794	(17,714)	196,080	(655)	195,425		2
3	Housekeeping	161,212	37,096		198,308		198,308		198,308		3
4	Laundry	31,121	10,260	2,000	43,381		43,381		43,381		4
5	Heat and Other Utilities			112,095	112,095		112,095		112,095		5
6	Maintenance	52,140	28,458	27,245	107,843		107,843	(5,993)	101,850		6
7	Other (specify):*			4,541	4,541		4,541		4,541		7
8	TOTAL General Services	438,125	312,363	154,469	904,957	(17,714)	887,243	(6,648)	880,595		8
	B. Health Care and Programs										
9	Medical Director			5,500	5,500		5,500		5,500		9
10	Nursing and Medical Records	1,742,643	62,074	9,935	1,814,652		1,814,652		1,814,652		10
10a	Therapy	66,917		7,510	74,427		74,427		74,427		10a
11	Activities	144,711	22,543	3,398	170,652		170,652		170,652		11
12	Social Services	8,699		3,040	11,739		11,739		11,739		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,962,970	84,617	29,383	2,076,970		2,076,970		2,076,970		16
	C. General Administration										
17	Administrative	213,872		514,698	728,570		728,570		728,570		17
18	Directors Fees										18
19	Professional Services			75,272	75,272		75,272		75,272		19
20	Dues, Fees, Subscriptions & Promotions			25,086	25,086		25,086	(20,194)	4,892		20
21	Clerical & General Office Expenses	107,633	10,058	27,118	144,809		144,809	(100)	144,709		21
22	Employee Benefits & Payroll Taxes			414,306	414,306	17,714	432,020		432,020		22
23	Inservice Training & Education			1,100	1,100		1,100		1,100		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,633	8,633		8,633	(460)	8,173		25
26	Insurance-Prop.Liab.Malpractice			195,531	195,531		195,531		195,531		26
27	Other (specify):*										27
28	TOTAL General Administration	321,505	10,058	1,261,744	1,593,307	17,714	1,611,021	(20,754)	1,590,267		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,722,600	407,038	1,445,596	4,575,234		4,575,234	(27,402)	4,547,832		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 PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	8,588
	REPAIRS & MAINTENANCE		0
			0
			8,588
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		2,000
			0
			2,000
5	HEAT & OTHER UTILITIES		
	GAS HEAT		47,440
	ELECTRICITY		49,918
	WATER		14,737
	CABLE TV - LOBBY		
			0
			112,095
6	MAINTENANCE		
	GROUNDS MAINTENANCE		2,790
	PAINTING & DECORATING		7,838
	BUILDING REPAIRS		3,000
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		42
	ELEVATOR MAINTENANCE & REPAIR		9,180
	OUTSIDE LABOR		310
	EXTERMINATING SERVICE		2,700
	FIRE SERVICE		1,385
			0
			0
			0
			27,245
7	OTHER		
	SCAVENGER		4,541
	SECURITY SERVICE		0
			4,541
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,500
			5,500

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	384
	LABORATORY & XRAY EXPENSE		3,803
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,128
	PHARMACY CONSULTANT	XVIII B 39-2	1,620
	UTILIZATION REVIEW FEES	XVIII B ___-2	0
	PHYSICIANS	XVIII B ___-2	0
	PSYCHIATRIC	XVIII B ___-2	0
	RN CONSULTANT	XVIII B 38-2	0
	DENTAL CONSULTANT		0
			0
			9,935
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,510
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			7,510
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
	CLERGY		3,398
			3,398
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	3,040
			0
			3,040
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	514,698
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	7,338
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	67,934
		0
		75,272
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	12,242
	EMPLOYEE WANT ADS XIX F	1,157
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	1,795
	LICENSES & PERMITS XIX F	1,440
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	6,407
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	845
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	200
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	500
		25,086
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	60
	EQUIPMENT REPAIR & MAINTENANCE	1,722
	OUTSIDE CLERICAL SERVICES	125
	PENALTIES / OVERDRAFT CHARGES VI 18	100
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	25,111
	MESSENGER SERVICE	0
		0
		27,118

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	201,789
	UNEMPLOYMENT COMPENSATION XIX D	15,813
	WORKERS COMPENSATION INSURANCE XIX D	50,150
	HOSPITALIZATION INSURANCE XIX D	137,515
	EMPLOYEE BENEFITS - OTHER XIX D	4,775
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	501 PLAN EXPENSE XIX D	0
	CHICAGO HEAD TAX XIX D	4,264
		414,306
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,100
		1,100
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,633
		8,633
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	195,531
		195,531
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,445,596

BIRCHWOOD PLAZA
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2004

TOTAL FOOD PURCHASE	213,794	PATIENT MEALS	161619
LESS SALES TAX	(655)	ADD EMPLOYEE MEALS	14640
NET FOOD	213,139	TOTAL MEALS/YEAR	176259
TOTAL PATIENT CENSUS	53,873	NET FOOD	213139
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	176259
TOTAL PATIENT MEALS	161619	COST PER MEAL	1.21
ADD # EMPLOYEE MEALS/DAY	40	TIME EMPLOYEE MEALS	14640
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	17714
TOTAL EMPLOYEE MEALS	14640		

BIRCHWOOD PLAZA PROFESSIONAL FEES 12/31/04		
ALPHA DATA	DATA PROCESSING	4,114
ILLINOIS BUSINESS SYSTEM	DATA PROCESSING	237
MUTUAL OF OMAHA	DATA PROCESSING	227
OMNICARE	SOFTWARE SUPPORT	2,760
FR&R	ACCOUNTING	625
KRUPNICK, BOKOR	ACCOUNTING	10,900
RICHARD PEELO	M/C COST REPORT	3,330
MYRON TUSHBAI	ACCOUNTING	9,274
AZULAY, HORN	LEGAL	3,514
RIEFF, SCHRAMM & KANTER	LEGAL	23,856
SIGEL, ALBIN, LANDAU, RUBIN	LEGAL	10,960
ECONOCARE	PURCHASING CONSULTANT	3,168
ADVANTAGE BENEFIT	501K ADMINISTRATOR	1,572
PERSONAL PLANNERS	UC CONSULTANT	735
		75,272

BIRCHWOOD PLAZA		ACCT #18370				
TRANSPORTATION - STAFF						
12/31/04						
	NAME	DEPARTMENT	PURPOSE	AMOUNT	AMOUNT	TOTAL
01/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	484.62		
01/04	MADU		MONTHLY AUTO REIMBURSEMENT	240.00		
01/04	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities		67.25	
01/04	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities		120.85	
02/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	323.08		
02/04	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities		125.97	
03/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	323.08		
03/04	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities		26.25	
03/04	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities		36.47	
04/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	323.08		
05/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	484.62		
04/04	LEITER - CAB FARE				(15.10)	
05/04	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities		127.97	
05/04	SECRETARY OF STATE		LICENSE PLATE RENEWAL		78.00	
06/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	323.08		
06/04	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities		41.59	
06/04	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities		822.55	
06/04	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities		29.57	
07/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	323.08		
07/04	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities		117.70	
07/04	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities		117.73	
08/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	323.08		
08/04	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities		127.27	
08/04	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities		35.25	
09/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	323.08		
09/04	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities		1,037.77	
09/04	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities		91.86	
09/04	AMOCO		Gasoline for facility banking, maintenance, marketing & activities		32.63	
09/04	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities		53.78	
10/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	484.62		
10/04	AMOCO		Gasoline for facility banking, maintenance, marketing & activities		14.14	
10/04	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities		88.85	
11/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	323.08		
11/04	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities		82.86	
11/04	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities		87.16	
11/04	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities		30.25	
12/04	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT	323.08		
12/04	IZET DURAUPOVIC		Gasoline for facility banking, maintenance, marketing & activities		25.00	
12/04	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities		42.40	
12/04	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities		125.77	
TOTAL				4,601.58	3,571.79	8,173.37

Facility Name & ID Number **BIRCHWOOD PLAZA**

#0028696

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			10,610	10,610		10,610	107,134	117,744			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,872	1,872		1,872	235,845	237,717			32
33	Real Estate Taxes			164,163	164,163		164,163		164,163			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(438,000)				34
35	Rent-Equipment & Vehicles			9,936	9,936		9,936		9,936			35
36	Other (specify):*											36
37	TOTAL Ownership			624,581	624,581		624,581	(95,021)	529,560			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,423	24,048	147,471		147,471		147,471			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,800	109,800		109,800		109,800			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		123,423	133,848	257,271		257,271		257,271			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,722,600	530,461	2,204,025	5,457,086		5,457,086	(122,423)	5,334,663			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:

01/01/2004

Ending:

12/31/2004

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(1,981)	30		9
10	Interest and Other Investment Income	(2,787)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(655)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(460)	25		16
17	Non-Care Related Fees	(845)	20		17
18	Fines and Penalties	(100)	21		18
19	Entertainment				19
20	Contributions	(700)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,242)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,407)	20		28
29	Other-Attach Schedule	(5,993)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (32,170)		\$	30

OHF 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	2	
		Amount	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)	(90,253)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (90,253)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (122,423)		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	2	3	4
		Yes	No	Amount	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	Exceptional Care Program		X		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: 01/01/2004

Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ -5993	6 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	(5,993)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD PLAZA# 0028696 Report Period Beginning:

01/01/2004

Ending: 12/31/2004

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	(655)	0	0	0	0	0	0	0	0	0	0	(655)	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	(5,993)	0	0	0	0	0	0	0	0	0	0	(5,993)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,648)	0	0	0	0	0	0	0	0	0	0	(6,648)	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	Nurse Aide 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	(20,194)	0	0	0	0	0	0	0	0	0	0	(20,194)	20
21	Clerical & General Office Expenses	(100)	0	0	0	0	0	0	0	0	0	0	(100)	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	(460)	0	0	0	0	0	0	0	0	0	0	(460)	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	(20,754)	0	0	0	0	0	0	0	0	0	0	(20,754)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,402)	0	0	0	0	0	0	0	0	0	0	(27,402)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIRCHWOOD PLAZA# 0028696

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,981)	109,115	0	0	0	0	0	0	0	0	0	107,134	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,787)	238,632	0	0	0	0	0	0	0	0	0	235,845	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(438,000)	0	0	0	0	0	0	0	0	0	(438,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,768)	(90,253)	0	(95,021)	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)	(32,170)	(90,253)	0	(122,423)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				BIRCHWOOD PLAZA ASSOCIATES	CHICAGO	REAL ESTATE RENTAL
	SEE ATTACHED					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 438,000	BIRCHWOOD PLAZA ASSOCIATES		\$	(438,000)	1
2	V	30 SL DEPRECIATION		" "		109,115	109,115	2
3	V	32 INTEREST		" "		238,632	238,632	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 438,000			\$ 347,747	\$ * (90,253)	14

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

Facility Name & ID Number

BIRCHWOOD PLAZA

#

0028696

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	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 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CHARLOTTE KOHN		MGMT CONSULT	0.00	62,743	30	40.00	MGMT FEES	\$ 514,698	17-3	1
2											2
3											3
4	RAMONA WEINGARTEN		ACTIVITIES	0.00	0	40	100.00	SALARY	26,086	11-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 540,784		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: **01/01/2004** Ending: **2/31/2004**

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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:

01/01/2004

Ending:

12/31/2004**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:					\$	\$			\$	1									
2	MB FINANCIAL		X	MORTGAGE	\$43,274.00	3/1/2004	6,000,000	5,864,929	3/5/2009	6.0000	293,744	2								
3	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS		3/1/2004	22,737	19,326			3,411	3								
4	LESS RELATED PARTY INTEREST INCOME										(58,523)	4								
5												5								
Working Capital																				
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$12,954.62	12/10/04	155,455	142,501	11/10/05		455	6								
7	MB FINANCIAL		X	LINE OF CREDIT FEE							800	7								
8	AMERICAN HONDA		X	AUTO LOAN	\$998.81	10/13/04	51,662	48,282	10/27/09	5.9000	617	8								
9	TOTAL Facility Related				\$57,227.43		\$ 6,229,854	\$ 6,075,038			\$ 240,504	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 6,229,854	\$ 6,075,038			\$ 240,504	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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.

1. Real Estate Tax accrual used on 2003 report.		\$	172,110	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.)		\$	167,404	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(4,706)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	169,080	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 \$ <u>211</u> For <u>1998</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(211)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	164,163	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	192,289	8
	2000	164,244	9
	2001	168,516	10
	2002	170,405	11
	2003	167,404	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 2003 TAX BILL.

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2003	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIRCHWOOD PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028696

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-29-302-011-0000</u>	<u>NURSING HOME</u>	\$ <u>2,572.04</u>	\$ <u>2,572.04</u>
2. <u>11-29-302-012-0000</u>	<u>NURSING HOME</u>	\$ <u>70,454.28</u>	\$ <u>70,454.28</u>
3. <u>11-29-302-020-0000</u>	<u>NURSING HOME</u>	\$ <u>94,377.32</u>	\$ <u>94,377.32</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>167,403.64</u>	\$ <u>167,403.64</u>

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 & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2004 Ending:

12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame STEEL & CONCRETE Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	<u>RELATED PARTY: BIRCHWOOD PLAZA ASSOC</u>			\$	1
2	<u>NURSING HOME</u>		<u>1984</u>	<u>80,569</u>	2
3	TOTALS			\$ 80,569	3

Facility Name & ID Number **BIRCHWOOD PLAZA**# **0028696**

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	RELATED PARTY: BIRCHWOOD PLAZA ASSOC			\$	\$		\$	\$	\$	4
5	192	1984		2,238,672		40	55,967	55,967	1,185,325	5
6										6
7										7
8										8
	Improvement Type**									
9	CONCRETE PAVING & RAILS	1984		13,495		20	531	531	13,495	9
10	SPRINKLER MODIFICATION	1984		2,752		25	110	110	2,250	10
11	LOBBY RENOVATION	1984		2,489		40	62	62	1,288	11
12	TERRACE RESURFACE	1984		7,600		15			7,600	12
13	FOYER RE-FLOORING	1984		1,835		20	83	83	1,835	13
14	BASEMENT RENOVATION	1985		18,061	1	40	452	451	9,451	14
15	NURSING STATION REMODELLING	1985		7,755		20	388	388	7,695	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	91	25	119	28	2,286	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	60	20	60		1,145	21
22	ELEVATOR OVERHAUL	1985		12,800	641	20	640	(1)	12,228	22
23	VARIOUS (ELECTRIC & SPRINKLER)	1986		5,486	126	20	274	148	5,162	23
24	ELECTRIC PANEL	1988		6,000	191	20	300	109	4,840	24
25	ELECTRICAL IMPROVEMENTS	1990		1,200	38	20	60	22	858	25
26	ELEVATOR IMPROVEMENTS	1990		15,600	495	20	780	285	11,285	26
27	TUCKPOINTING & BRICKWORK	1990		12,300	391	20	615	224	8,437	27
28	LAUNDRY ROOM DUCTWORK	1990		3,000	95	20	150	55	2,070	28
29	BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR	1994		282,054	7,336	20	14,103	6,767	153,735	29
30	DRAPERY	1994		7,933		5			7,933	30
31	ROOF & PARKING LOT IMPROVEMENTS	1995		69,984	1,992	15	4,666	2,674	42,423	31
32	ENLARGE PATIENT ROOMS(TRANS TO XI-C 97 AUDIT)	1997			149	39	149		968	32
33	WINDOWS	1998		41,775	615	25	1,671	1,056	11,697	33
34	SIDING	1998		20,000	513	25	800	287	5,600	34
35	PATIENT ROOM EXHAUST SYSTEM	1998		9,720	486	20	486		2,997	35
36	ELEVATOR SAFETY DEVICES	1998		5,350	357	15	357		2,261	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**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:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BUILDING EXTENSION (1994) ALLOWED FOR 1998	1998	\$ 49,866	\$	20	\$ 2,493	\$ 2,493	\$ 17,451	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		8,299	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		3,845	39
40	CARPETING / DRAPERIES	2000	5,062	452	7	723	271	3,254	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		1,077	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		681	42
43	ELEVATOR UPGRADE / FRONT OUTDOOR WALL SYSTEM	2001	89,217	3,244	27.5	3,244		11,760	43
44	CARPETING	2001	8,264	666	7	1,181	515	4,133	44
45	DRAPERIES	2001	7,753	893	7	1,108	215	3,324	45
46	WALLPAPER / CARPETTING	2002	18,309	2,461	7	2,616	155	6,540	46
47	NURSES STATION	2002	15,101	549	27.5	549		1,441	47
48	WALLPAPER / ELEVATOR UPGRADE	2003	13,835	503	27.5	503		890	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62	ADJ TO SL			72,895			(72,895)		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,110,511	\$ 97,869		\$ 97,869	\$	\$ 1,582,945	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 387,472	\$ 9,791	\$ 9,791	\$	5-15 YRS	\$ 343,146	71
72	Current Year Purchases					10-15 YRS		72
73	Fully Depreciated Assets	279,548					279,548	73
74	FROM XI-B (97 AUDIT)	14,550	1,455	1,455		10 YRS	10,185	74
75	TOTALS	\$ 681,570	\$ 11,246	\$ 11,246	\$		\$ 632,879	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	BANKING,PURCHASING,	'05 ACURA	2004	\$ 69,032	\$ 10,610	\$ 8,629	\$ (1,981)	4 YRS	\$ 8,629	76
77	ADMINISTRATIVE,ETC									77
78										78
79										79
80	TOTALS			\$ 69,032	\$ 10,610	\$ 8,629	\$ (1,981)		\$ 8,629	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)	\$ 3,941,682	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,725	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 117,744	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,981)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,224,453	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.

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: _____ *

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: \$ **150**

Description: **FREEZER**

(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	ADMIN,BANKING, /	'01 LEXUS RX300	\$ 815.15	\$ 9,786	17
18	PURCHASING,				18
19	MAINT,ETC				19
20					20
21	TOTAL		\$ 815.15	\$ 9,786	21

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. _____ /2005 \$ _____

13. _____ /2006 \$ _____

14. _____ /2007 \$ _____

* 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.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	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	\$		\$ 518	\$		\$ 518	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			23,530			23,530	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				72,240		72,240	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): MEDICAL SUPPLIES	39-2					51,183		51,183	13
14	TOTAL			\$		\$ 24,048	\$ 123,423		\$ 147,471	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **BIRCHWOOD PLAZA**
XV. BALANCE SHEET - Unrestricted Operating Fund.

0028696
 As of **12/31/2004**

Report Period Beginning: **01/01/2004**
 (last day of reporting year)

Ending: **12/31/2004**

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 290,628	\$ 340,522	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,234,568	1,234,568	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	180,453	180,453	6
7	Other Prepaid Expenses	13,867	39,288	7
8	Accounts Receivable (owners or related parties)		150,000	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,719,516	\$ 1,944,831	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		880,844	15
16	Equipment, at Historical Cost	69,032	758,598	16
17	Accumulated Depreciation (book methods)	(10,610)	(3,196,773)	17
18	Deferred Charges		19,326	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): NY LIFE INSUR.CONTRACTS	224,084	224,084	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 282,506	\$ 999,245	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,002,022	\$ 2,944,076	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 85,357	\$ 85,357	26
27	Officer's Accounts Payable	80,614	80,614	27
28	Accounts Payable-Patient Deposits	48,610	48,610	28
29	Short-Term Notes Payable	190,783	190,783	29
30	Accrued Salaries Payable	106,479	106,479	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,938	33,938	31
32	Accrued Real Estate Taxes(Sch.IX-B)		169,080	32
33	Accrued Interest Payable			33
34	Deferred Compensation	174,106	174,106	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	121,892	121,892	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 841,779	\$ 1,010,859	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,864,929	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO BP ASSOC	1,277,989		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,277,989	\$ 5,864,929	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,119,768	\$ 6,875,788	46
47	TOTAL EQUITY(page 18, line 24)	\$ (117,746)	\$ (3,931,712)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,002,022	\$ 2,944,076	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (450,485)	1
2	Restatements (describe):		2
3	2003 IL REPLACEMENT TAX	(17,197)	3
4	ROUNDING	4	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (467,678)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,110,894	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	(760,962)	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)	\$ 349,932	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)	\$ (117,746)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,398,254	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,398,254	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	126,407	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 126,407	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	578	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)	\$ 578	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,787	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,787	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	501K PLAN CASH VALUE ADJ	39,954	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 39,954	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,567,980	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	904,957	31
32	Health Care	2,076,970	32
33	General Administration	1,593,307	33
	B. Capital Expense		
34	Ownership	624,581	34
	C. Ancillary Expense		
35	Special Cost Centers	147,471	35
36	Provider Participation Fee	109,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,457,086	40
41	Income before Income Taxes (line 30 minus line 40)**	1,110,894	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,110,894	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

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	4,083	\$ 153,614	\$ 33.09	1
2	Assistant Director of Nursing				2
3	Registered Nurses	25,838	769,621	26.34	3
4	Licensed Practical Nurses	5,317	119,995	19.69	4
5	Nurse Aides & Orderlies	63,661	699,413	10.11	5
6	Nurse Aide Trainees				6
7	Licensed Therapist	4,229	66,917	13.16	7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	13,329	144,711	10.24	10
11	Social Service Workers	438	8,699	19.86	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,907	38,061	17.04	14
15	Cook Helpers/Assistants	5,419	57,507	9.41	15
16	Dishwashers	10,859	98,084	8.23	16
17	Maintenance Workers	2,992	52,140	16.51	17
18	Housekeepers	16,013	161,212	9.19	18
19	Laundry	3,853	31,121	7.34	19
20	Administrator	2,152	162,769	52.25	20
21	Assistant Administrator	2,065	51,103	24.03	21
22	Other Administrative				22
23	Office Manager	2,866	41,249	10.51	23
24	Clerical	5,610	66,384	10.84	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)	170,631	\$ 2,722,600 *	\$ 14.38	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	\$ 8,588	1-3	35
36	Medical Director	5,500	9-3	36
37	Medical Records Consultant	4,128	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	1,620	10-3	39
40	Physical Therapy Consultant	0	10a-3	40
41	Occupational Therapy Consultant	7,510	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	0	11-3	44
45	Social Service Consultant	3,040	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 30,386		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 384	10-3	50
51	Licensed Practical Nurses	0	10-3	51
52	Nurse Aides	0	10-3	52
53	TOTAL (lines 50 - 52)	\$ 384		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
ABRAHAM SCHIFFMAN	ADMIN		\$ 162,769	Workers' Compensation Insurance	\$ 50,150	IDPH License Fee	\$		
JOYCE GRODETZ	ASST ADMIN		51,103	Unemployment Compensation Insurance	15,813	Advertising: Employee Recruitment	1,157		
				FICA Taxes	201,789	Health Care Worker Background Check	500		
				Employee Health Insurance	137,515	(Indicate # of checks performed <u>42</u>)			
				Employee Meals	17,714	MARKETING/ADV/PROMO	18,649		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,545		
				EMPLOYEE BENEFITS - OTHER	4,775	LICENSES & PERMITS	1,440		
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	1,795		
				PENSION/PROFIT SHARING PLANS	0				
				CHICAGO HEAD TAX	4,264	TRUST/FRANCHISE/CONTRIB/ETC	(1,545)		
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)		
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(12,242)		
						Yellow page advertising	(6,407)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 213,872	TOTAL (agree to Schedule V, line 22, col.8)	\$ 432,020	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,892		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
CHARLOTTE KOHN	MANAGEMENT FEES		\$ 514,698				Out-of-State Travel	\$	
							In-State Travel	0	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 514,698				Seminar Expense	0	
C. Professional Services							Entertainment Expense	()	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
			\$				TOTAL	\$	
SEE SCHEDULE ATTACHED			75,272	TOTAL					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 75,272						

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY2001	7 FY2002	8 FY2003	9 FY2004	10 FY2005	11 FY2006	12 FY2007	13 FY2008	14 FY2009
					1	PAINT/DECORATING	2001	\$ 3,239	3	\$ 540	\$ 1,080	\$ 1,080	\$ 539
2	PAINT/DECORATING	2004	7,838	3				1,306	2,613	2,613	1,306		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 11,077		\$ 540	\$ 1,080	\$ 1,080	\$ 1,845	\$ 2,613	\$ 2,613	\$ 1,306	\$	\$

Facility Name & ID Number **BIRCHWOOD PLAZA**# **0028696**Report Period Beginning: **01/01/2004**Ending: **12/31/2004****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? _____ 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. \$ _____ 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 of Public Aid during this cost report period. \$ 109,800
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 of Public Aid, 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. \$ 17,714 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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees