

		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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.

<p>I. IDPH Facility ID Number: <u>0028696</u></p> <p>Facility Name: <u>BIRCHWOOD PLAZA</u></p> <p>Address: <u>1426 WEST BIRCHWOOD</u> <u>CHICAGO</u> <u>60626</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 274-4405</u> Fax # <u>(773) 274-4763</u></p> <p>IDPA ID Number: <u>36-330652201</u></p> <p>Date of Initial License for Current Owners: <u>06/17/84</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>CHARLOTTE KOHN</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>EXECUTIVE DIRECTOR</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td colspan="2"> 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 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>CHARLOTTE KOHN</u> (Date) _____		(Title) <u>EXECUTIVE DIRECTOR</u>	Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	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	
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Facility Name & ID Number BIRCHWOOD PLAZA

0028696 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	73,000	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	38,612	10,067	2,870	51,549	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,612	10,067	2,870	51,549	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.62%

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

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

NONE

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

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

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 6/17/84

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/17/84 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 2,483

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **BIRCHWOOD PLAZA** # **0028696** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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	210,191	25,675	8,500	244,366		244,366		244,366		1
2	Food Purchase		214,619		214,619	(18,396)	196,223	(973)	195,250		2
3	Housekeeping	184,601	31,661		216,262		216,262		216,262		3
4	Laundry	33,952	8,761		42,713		42,713		42,713		4
5	Heat and Other Utilities			143,709	143,709		143,709		143,709		5
6	Maintenance	46,495	32,673	22,526	101,694		101,694	(782)	100,912		6
7	Other (specify):*			5,145	5,145		5,145		5,145		7
8	TOTAL General Services	475,239	313,389	179,880	968,508	(18,396)	950,112	(1,755)	948,357		8
	B. Health Care and Programs										
9	Medical Director			16,500	16,500		16,500		16,500		9
10	Nursing and Medical Records	1,765,472	80,530	14,970	1,860,972		1,860,972		1,860,972		10
10a	Therapy	68,940	1,890	238	71,068		71,068		71,068		10a
11	Activities	111,614	12,547	4,189	128,350		128,350		128,350		11
12	Social Services	62,974		3,020	65,994		65,994		65,994		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,009,000	94,967	38,917	2,142,884		2,142,884		2,142,884		16
	C. General Administration										
17	Administrative	214,072		529,796	743,868		743,868		743,868		17
18	Directors Fees										18
19	Professional Services			59,450	59,450		59,450		59,450		19
20	Dues, Fees, Subscriptions & Promotions			64,247	64,247		64,247	(49,766)	14,481		20
21	Clerical & General Office Expenses	118,467	10,511	38,710	167,688		167,688	(1,494)	166,194		21
22	Employee Benefits & Payroll Taxes			531,769	531,769	18,396	550,165		550,165		22
23	Inservice Training & Education			604	604		604		604		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			7,305	7,305		7,305		7,305		25
26	Insurance-Prop.Liab.Malpractice			217,173	217,173		217,173		217,173		26
27	Other (specify):*			19,797	19,797		19,797	(19,797)			27
28	TOTAL General Administration	332,539	10,511	1,468,851	1,811,901	18,396	1,830,297	(71,057)	1,759,240		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,816,778	418,867	1,687,648	4,923,293		4,923,293	(72,812)	4,850,481		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	8,500
	REPAIRS & MAINTENANCE		0
			0
			8,500
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		79,406
	ELECTRICITY		51,378
	WATER		12,925
	CABLE TV - LOBBY		0
			0
			143,709
6	MAINTENANCE		
	GROUNDS MAINTENANCE		1,472
	PAINTING & DECORATING		4,075
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		1,705
	ELEVATOR MAINTENANCE & REPAIR		9,748
	OUTSIDE LABOR		1,436
	EXTERMINATING SERVICE		2,700
	FIRE SERVICE		1,390
			0
			0
			0
			22,526
7	OTHER		
	SCAVENGER		5,145
	SECURITY SERVICE		0
			5,145
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	16,500
			16,500

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	4,090
	LABORATORY & XRAY EXPENSE		3,888
	PURCHASED SERVICES		1,148
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,224
	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
			14,970
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		238
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			238
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
	CLERGY		4,189
			4,189
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	3,020
			0
			3,020
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	529,796
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	7,646
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	51,804
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	59,450
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	18,307
	EMPLOYEE RECRUITMENT / WANT ADS XIX F	8,943
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,475
	LICENSES & PERMITS XIX F	3,543
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	31,059
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	400
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	520
21	CLERICAL & GENERAL OFFICE EXPENSES	64,247
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	86
	EQUIPMENT REPAIR & MAINTENANCE	5,709
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	1,494
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	31,421
	MESSENGER SERVICE	0
		0
		38,710

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	207,318
	UNEMPLOYMENT COMPENSATION XIX D	22,585
	WORKERS COMPENSATION INSURANCE XIX D	62,366
	HOSPITALIZATION INSURANCE XIX D	143,553
	EMPLOYEE BENEFITS - OTHER XIX D	3,403
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	UNION PENSION XIX D	12,500
	501 PLAN EXPENSE XIX D	75,624
	CHICAGO HEAD TAX XIX D	4,420
		531,769
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	604
		604
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,305
		7,305
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	217,173
		217,173
27	OTHER	
	BAD DEBTS VI 24	19,797
		19,797

GRAND TOTAL COLUMN 3 OTHER 1,687,648

BIRCHWOOD PLAZA
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	214,619	PATIENT MEALS	154647
LESS SALES TAX	(973)	ADD EMPLOYEE MEALS	14600
-----		-----	
NET FOOD	213,646	TOTAL MEALS/YEAR	169247
TOTAL PATIENT CENSUS	51,549	NET FOOD	213646
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	169247
-----		-----	
TOTAL PATIENT MEALS	154647	COST PER MEAL	1.26
		TIME EMPLOYEE MEALS	14600
ADD # EMPLOYEE MEALS/DAY	40	-----	
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	18396
-----		=====	
TOTAL EMPLOYEE MEALS	14600		

BIRCHWOOD PLAZA PROFESSIONAL FEES 12/31/05		
ALPHA DATA	DATA PROCESSING	4,388
MUTUAL OF OMAHA	DATA PROCESSING	198
OMNICARE	SOFTWARE SUPPORT	3,060
KRUPNICK, BOKOR	ACCOUNTING	19,600
FR&R	ACCOUNTING	330
RICHARD PEELO	M/C COST REPORT	3,000
MYRON TUSHBAI	ACCOUNTING	8,385
RICHARD BIRNBAUM	LEGAL	1,880
NEAL ,GERBER & EISENBERG	LEGAL	5,166
SIGEL, ALBIN, LANDAU, RUBIN	LEGAL	7,418
RIEFF, SCHRAMM & KANTER	LEGAL	126
ECONOCARE	PURCHASING CONSULTANT	3,456
ADVANTAGE BENEFIT	501K ADMINISTRATOR	1,603
PERSONAL PLANNERS	UC CONSULTANT	840

		59,450

BIRCHWOOD PLAZA		ACCT #18370				
TRANSPORTATION - STAFF						
12/31/05						
	NAME	DEPARTMENT	PURPOSE	AMOUNT	AMOUNT	TOTAL
01/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		323.08	
01/05	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities	101.38		
01/05	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities	8.00		
02/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		323.08	
02/05	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities	39.77		
02/05	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities	31.25		
03/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		323.08	
03/05	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities	42.60		
03/05	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities	174.58		
03/05	AMERICAN EXPRESS		HONDA FIN	220.67		
04/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		484.62	
04/05	SEC ST		LICENSE PLAT RENEWAL	78.00		
05/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		323.08	
05/05	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities	83.87		
05/05	SECRETARY OF STATE		LICENSE PLATE RENEWAL	100.00		
06/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		161.54	
06/05	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities	88.84		
06/05	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities	7.00		
06/05	ALMAJA SUVALIJA		Gasoline for facility banking, maintenance, marketing & activities	55.74		
06/05	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities	44.00		
07/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		484.62	
07/05	K SILVESTRI		Gasoline for facility banking, maintenance, marketing & activities	10.80		
08/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		323.08	
08/05	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities	469.38		
08/05	K SILVESTRI		Gasoline for facility banking, maintenance, marketing & activities	17.40		
08/05	A SUVALISA		Gasoline for facility banking, maintenance, marketing & activities	87.12		
09/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		323.08	
09/05	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities	166.79		
09/05	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities	125.08		
09/05	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities	12.00		
09/05	AMERICAN EXPRESS		Gasoline for facility banking, maintenance, marketing & activities	124.01		
09/05	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities	185.65		
10/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		484.62	
10/05	A SUVALISA		Gasoline for facility banking, maintenance, marketing & activities	31.83		
11/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		323.08	
11/05	CITY OF EVANSTON		Gasoline for facility banking, maintenance, marketing & activities	60.00		
11/05	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities	143.62		
11/05	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities	11.50		
12/05	JOYCE GRODETZ		MONTHLY AUTO REIMBURSEMENT		323.08	
12/05	PETTY CASH		Gasoline for facility banking, maintenance, marketing & activities	8.25		
12/05	CITIBANK AADVANTAGE		Gasoline for facility banking, maintenance, marketing & activities	576.28		
TOTAL				3,105.41	4,200.04	7,305.45

Facility Name & ID Number **BIRCHWOOD PLAZA**

#0028696

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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			4,800	4,800		4,800	120,696	125,496			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,280	9,280		9,280	323,243	332,523			32
33	Real Estate Taxes			174,495	174,495		174,495		174,495			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(438,000)				34
35	Rent-Equipment & Vehicles			9,786	9,786		9,786		9,786			35
36	Other (specify):* STORAGE			907	907		907		907			36
37	TOTAL Ownership			637,268	637,268		637,268	5,939	643,207			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,889	19,434	167,323		167,323		167,323			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		147,889	128,934	276,823		276,823		276,823			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,816,778	566,756	2,453,850	5,837,384		5,837,384	(66,873)	5,770,511			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:

01/01/2005

Ending:

12/31/2005

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	12,458	30		9
10	Interest and Other Investment Income	(7,672)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(973)	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	(400)	20		17
18	Fines and Penalties	(1,494)	21		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	(19,797)	27		24
25	Fund Raising, Advertising and Promotional	(18,307)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(31,059)	20		28
29	Other-Attach Schedule <u>DEFERRED MAINTENANCE</u>	(782)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (68,026)		\$	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)	1,153		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,153		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (66,873)		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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (782)	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	(782)		49

STATE OF ILLINOIS

Summary A

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

01/01/2005

Ending: 12/31/2005

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(973)	0	0	0	0	0	0	0	0	0	0	(973)	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	(782)	0	0	0	0	0	0	0	0	0	0	(782)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,755)	0	(1,755)	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	(49,766)	0	0	0	0	0	0	0	0	0	0	(49,766)	20
21	Clerical & General Office Expenses	(1,494)	0	0	0	0	0	0	0	0	0	0	(1,494)	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):*	(19,797)	0	0	0	0	0	0	0	0	0	0	(19,797)	27
28	TOTAL General Administration	(71,057)	0	(71,057)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(72,812)	0	(72,812)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	12,458	108,238	0	0	0	0	0	0	0	0	0	120,696	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,672)	330,915	0	0	0	0	0	0	0	0	0	323,243	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	4,786	1,153	0	5,939	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)	(68,026)	1,153	0	(66,873)	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		" "		108,238	108,238	2
3	V	32 INTEREST		" "		330,915	330,915	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 438,000			\$ 439,153	\$ * 1,153	14

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

Facility Name & ID Number

BIRCHWOOD PLAZA

#

0028696

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	EXEC. DIRECTOR	MGMT CONSULT	0.00	62,571	30	40.00	MGMT FEES	\$ 529,796	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 529,796		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: **01/01/2005** Ending: **2/31/2005**

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:

01/01/2005

Ending:

12/31/2005**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	5,711,358	3/5/2009	6.0000	326,368	2								
3	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS		3/1/2004	22,737	14,779			4,547	3								
4	LESS RELATED PARTY INTEREST INCOME											4								
5												5								
Working Capital																				
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$12,954.62	12/10/04	155,455		11/10/05	3.6369	3,285	6								
7	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$13,983.99	6/1/05	159,817	97,888	6/1/06	5.0000	3,330	7								
8	AMERICAN HONDA		X	AUTO LOAN	\$998.81	10/13/04	51,662	40,361	10/27/09	5.9000	2,665	8								
9	TOTAL Facility Related				\$71,211.42		\$ 6,389,671	\$ 5,864,386			\$ 340,195	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 6,389,671	\$ 5,864,386			\$ 340,195	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 2004 report.		\$	169,080	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.)		\$	171,122	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,042	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	172,830	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>377</u> For <u>1998</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(377)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	174,495	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	164,244	8
	2001	168,516	9
	2002	170,405	10
	2003	167,404	11
	2004	171,122	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 2004 TAX BILL.

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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, CNA 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:

01/01/2005 Ending: 12/31/2005

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	1,241,292	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	110	110	2,360	10
11		LOBBY RENOVATION	1984		2,489		40	62	62	1,350	11
12		TERRACE RESURFACE	1984		7,600		15			7,600	12
13		FOYER RE-FLOORING	1984		1,835		20			1,835	13
14		BASEMENT RENOVATION	1985		18,061	1	40	452	451	9,903	14
15		NURSING STATION REMODELLING	1985		7,755		20	60	60	7,755	15
16		ASPHALT ROOF	1985		7,000		15			7,000	16
17		NURSE CALL SYSTEM REWIRE	1985		4,066		15			4,066	17
18		SPRINKLER MODIFICATION	1985		2,963		25	119	119	2,405	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	55	55	1,200	21
22		ELEVATOR OVERHAUL	1985		12,800	121	20	572	451	12,800	22
23		VARIOUS (ELECTRIC & SPRINKLER)	1986		5,486		20	274	274	5,436	23
24		ELECTRIC PANEL	1988		6,000	191	20	300	109	5,140	24
25		ELECTRICAL IMPROVEMENTS	1990		1,200	38	20	60	22	918	25
26		ELEVATOR IMPROVEMENTS	1990		15,600	495	20	780	285	12,065	26
27		TUCKPOINTING & BRICKWORK	1990		12,300	391	20	615	224	9,052	27
28		LAUNDRY ROOM DUCTWORK	1990		3,000	95	20	150	55	2,220	28
29		BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR	1994		282,054	7,336	20	14,103	6,767	167,838	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	47,089	31
32		ENLARGE PATIENT ROOMS(TRANS TO XI-C 97 AUDIT)	1997			149	39	149		1,117	32
33		WINDOWS	1998		41,775	615	25	1,671	1,056	13,368	33
34		SIDING	1998		20,000	513	25	800	287	6,400	34
35		PATIENT ROOM EXHAUST SYSTEM	1998		9,720	486	20	486		3,483	35
36		ELEVATOR SAFETY DEVICES	1998		5,350	357	15	357		2,618	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:

01/01/2005 Ending: 12/31/2005

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	\$ 19,944	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		9,808	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		4,544	39
40	CARPETING / DRAPERIES	2000	5,062	451	7	723	272	3,977	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		1,310	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		869	42
43	ELEVATOR UPGRADE / FRONT OUTDOOR WALL SYSTEM	2001	89,217	3,244	27.5	3,244		15,004	43
44	CARPETING	2001	8,264	666	7	1,181	515	5,314	44
45	DRAPERIES	2001	7,753	893	7	1,108	215	4,432	45
46	WALLPAPER / CARPETTING	2002	18,309	1,476	7	2,616	1,140	9,156	46
47	NURSES STATION	2002	15,101	549	27.5	549		1,990	47
48	WALLPAPER / ELEVATOR UPGRADE	2003	13,835	503	27.5	503		1,393	48
49	WALLPAPER / CARPENTRY	2004	46,774	1,701	27.5	1,701		1,980	49
50	WALLPAPER / CARPENTRY / REMODELING	2005	18,014	316	27.5	316		316	50
51	CIRCULATING PUMP	2005	4,139	56	27.5	56		56	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			73,663			(73,663)		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,179,438	\$ 98,927		\$ 98,927	\$	\$ 1,682,151	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	\$ 76,073	\$ 7,037	\$ 7,037	\$	5-15 YRS	\$ 29,515	71
72	Current Year Purchases	15,633	819	819		8-15 YRS	819	72
73	Fully Depreciated Assets	127,253					127,253	73
74	FROM XI-B (97 AUDIT)	14,550	1,455	1,455		10 YRS	11,640	74
75	TOTALS	\$ 233,509	\$ 9,311	\$ 9,311	\$		\$ 169,227	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	\$ 4,800	\$ 17,258	\$ 12,458	4 YRS	\$ 25,887	76
77	ADMINISTRATIVE,ETC									77
78										78
79	FACILITY VAN		1998	13,600				4 YRS	13,600	79
80	TOTALS			\$ 82,632	\$ 4,800	\$ 17,258	\$ 12,458		\$ 39,487	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)	\$ 3,576,148	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 113,038	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,496	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,458	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,890,865	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: \$ _____ 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	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.	/2006	\$ _____
13.	/2007	\$ _____
14.	/2008	\$ _____

* 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 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.)

<p>1. HAVE YOU TRAINED CNAs 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>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 CNA _____</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 CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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	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.)

	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	39-3	hrs			665				665	2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	39-3	hrs			18,769				18,769	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 prescripts				105,269			105,269	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					42,620			42,620	13	
14	TOTAL			\$		\$	19,434	\$	147,889	\$	167,323	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**
XV. BALANCE SHEET - Unrestricted Operating Fund.

0028696
 As of **12/31/2005**

Report Period Beginning: **01/01/2005**
 (last day of reporting year)

Ending: **12/31/2005**

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	\$ 802,917	\$ 852,134	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,290,403	1,290,403	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	104,251	129,462	7
8	Accounts Receivable (owners or related parties)		350,000	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,197,571	\$ 2,621,999	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		905,997	15
16	Equipment, at Historical Cost	69,032	774,231	16
17	Accumulated Depreciation (book methods)	(15,410)	(3,239,576)	17
18	Deferred Charges		14,779	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	201,593	201,593	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 255,215	\$ 970,190	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,452,786	\$ 3,592,189	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 212,820	\$ 212,820	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	54,816	54,816	28
29	Short-Term Notes Payable	97,888	97,888	29
30	Accrued Salaries Payable	117,170	117,170	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,438	38,438	31
32	Accrued Real Estate Taxes(Sch.IX-B)		172,830	32
33	Accrued Interest Payable	605	605	33
34	Deferred Compensation	228,023	228,023	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	163,587	163,587	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 913,347	\$ 1,086,177	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	40,361	40,361	39
40	Mortgage Payable		5,711,358	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO BP ASSOC	999,875		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,040,236	\$ 5,751,719	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,953,583	\$ 6,837,896	46
47	TOTAL EQUITY(page 18, line 24)	\$ 499,203	\$ (3,245,707)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,452,786	\$ 3,592,189	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (117,746)	1
2	Restatements (describe):		2
3	2004 IL REPLACEMENT TAX	(13,760)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (131,506)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,253,632	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	(622,923)	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)	\$ 630,709	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)	\$ 499,203	24 *

* This must agree with page 17, line 47.

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	\$ 6,727,312	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,727,312	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	119,583	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 119,583	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	1,818	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)	\$ 1,818	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,672	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,672	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	LIFE INSURANCE PAY-OUT	250,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 250,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,106,385	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	968,508	31
32	Health Care	2,142,884	32
33	General Administration	1,811,901	33
B. Capital Expense			
34	Ownership	637,268	34
C. Ancillary Expense			
35	Special Cost Centers	167,323	35
36	Provider Participation Fee	109,500	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	15,369	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,852,753	40
41	Income before Income Taxes (line 30 minus line 40)**	1,253,632	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,253,632	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: 01/01/2005

Ending:

12/31/2005

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	3,963	4,502	\$ 154,234	\$ 34.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,355	26,450	711,169	26.89	3
4	Licensed Practical Nurses	7,649	8,462	174,130	20.58	4
5	CNAs & Orderlies	64,371	69,647	723,604	10.39	5
6	CNA Trainees					6
7	Licensed Therapist	4,318	5,328	68,940	12.94	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,936	11,617	111,614	9.61	10
11	Social Service Workers	2,778	3,034	62,974	20.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,033	2,322	42,846	18.45	14
15	Cook Helpers/Assistants	5,645	6,391	63,695	9.97	15
16	Dishwashers	10,580	11,741	103,650	8.83	16
17	Maintenance Workers	2,238	2,425	46,495	19.17	17
18	Housekeepers	17,004	18,981	184,601	9.73	18
19	Laundry	3,876	4,260	33,952	7.97	19
20	Administrator	2,084	3,124	175,772	56.27	20
21	Assistant Administrator	2,086	2,150	33,300	15.49	21
22	Other Administrative	173	173	5,000	28.90	22
23	Office Manager	4,173	4,927	43,934	8.92	23
24	Clerical	6,059	6,405	74,533	11.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>MDS CLERK</u>	117	117	2,335	19.96	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,438	192,056	\$ 2,816,778 *	\$ 14.67	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	M	\$ 8,500	1-3	35
36	Medical Director	O	16,500	9-3	36
37	Medical Records Consultant	N	4,224	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,620	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	3,020	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,864		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	136	\$ 4,090	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	136	\$ 4,090		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	0	\$ 175,772	Workers' Compensation Insurance	\$ 62,366	IDPH License Fee	\$ 200	
JOYCE GRODETZ	ASST ADMIN	0	33,300	Unemployment Compensation Insurance	22,585	Advertising: Employee Recruitment	8,943	
AHARON ADLER	OTHER ADMIN	0	5,000	FICA Taxes	207,318	Health Care Worker Background Check	520	
				Employee Health Insurance	143,553	(Indicate # of checks performed <u>52</u>)		
				Employee Meals	18,396	MARKETING/ADV/PROMO	49,366	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	400	
				EMPLOYEE BENEFITS - OTHER	3,403	LICENSES & PERMITS	3,343	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	1,475	
				PENSION/PROFIT SHARING PLANS	75,624			
				CHICAGO HEAD TAX	4,420	TRUST/FRANCHISE/CONTRIB/ETC	(400)	
				UNION PENSION	12,500	Less: Public Relations Expense	(0)	
						Non-allowable advertising	(18,307)	
						Yellow page advertising	(31,059)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 214,072	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 550,165		\$ 14,481		
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		\$ 529,796				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)			\$ 529,796				Seminar Expense	0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 59,450	TOTAL		\$	TOTAL	\$

SEE SCHEDULE ATTACHED

* 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	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATING	2004	\$ 7,838	3	\$	\$	\$ 1,306	\$ 2,613	\$ 2,613	\$ 1,306	\$	\$								
2	PAINT/DECORATING	2005	4,075				680	1,358	1,358	679										
3																				
4																				
5																				
6																				
7																				
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16																				
17																				
18																				
19																				
20	TOTALS		\$ 11,913		\$	\$	\$ 1,306	\$ 3,293	\$ 3,971	\$ 2,664	\$ 679	\$								

Facility Name & ID Number **BIRCHWOOD PLAZA**# **0028696**Report Period Beginning: **01/01/2005**Ending: **12/31/2005****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,500
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 18,396 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