

Facility Name & ID Number BIRCHWOOD PLAZA

0028696 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	39,099	11,732	2,863	53,694	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,099	11,732	2,863	53,694	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.55%

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 2,481

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: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **BIRCHWOOD PLAZA** # **0028696** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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	212,963	28,708	10,277	251,948		251,948	0	251,948		1
2	Food Purchase		223,556		223,556	(18,542)	205,014	(1,010)	204,004		2
3	Housekeeping	195,185	37,867	0	233,052		233,052	0	233,052		3
4	Laundry	36,742	9,503	0	46,245	0	46,245	0	46,245		4
5	Heat and Other Utilities			119,163	119,163		119,163	0	119,163		5
6	Maintenance	49,295	23,122	19,723	92,140		92,140	2,285	94,425		6
7	Other (specify):*			5,879	5,879		5,879	0	5,879		7
8	TOTAL General Services	494,185	322,756	155,042	971,983	(18,542)	953,441	1,275	954,716		8
	B. Health Care and Programs										
9	Medical Director	0		18,000	18,000		18,000	0	18,000		9
10	Nursing and Medical Records	1,872,697	93,239	13,524	1,979,460		1,979,460	0	1,979,460		10
10a	Therapy	73,976		0	73,976		73,976	0	73,976		10a
11	Activities	114,776	10,317	3,480	128,573		128,573	0	128,573		11
12	Social Services	45,579		2,400	47,979		47,979	0	47,979		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			85	85		85	0	85		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	2,107,028	103,556	37,489	2,248,073	0	2,248,073	0	2,248,073		16
	C. General Administration										
17	Administrative	256,079		570,373	826,452		826,452	0	826,452		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			60,940	60,940		60,940	0	60,940		19
20	Dues, Fees, Subscriptions & Promotions			48,236	48,236		48,236	(33,120)	15,116		20
21	Clerical & General Office Expenses	121,986	11,475	33,617	167,078		167,078	(140)	166,938		21
22	Employee Benefits & Payroll Taxes			501,847	501,847	18,542	520,389	0	520,389		22
23	Inservice Training & Education			530	530		530	0	530		23
24	Travel and Seminar			0	0		0	0	0		24
25	Other Admin. Staff Transportation			7,456	7,456		7,456	0	7,456		25
26	Insurance-Prop.Liab.Malpractice			219,598	219,598		219,598	0	219,598		26
27	Other (specify):*			0	0		0	0	0		27
28	TOTAL General Administration	378,065	11,475	1,442,597	1,832,137	18,542	1,850,679	(33,260)	1,817,419		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,979,278	437,787	1,635,128	5,052,193	0	5,052,193	(31,985)	5,020,208		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	10,277
	REPAIRS & MAINTENANCE	0
		0
		10,277
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	50,227
	ELECTRICITY	56,193
	WATER	12,743
	CABLE TV - LOBBY	0
		0
		119,163
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,874
	PAINTING & DECORATING	1,686
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,037
	ELEVATOR MAINTENANCE & REPAIR	6,063
	OUTSIDE LABOR	913
	EXTERMINATING SERVICE	2,700
	FIRE SERVICE	1,450
		0
		0
		0
		0
		19,723
7	OTHER	
	SCAVENGER	5,879
	SECURITY SERVICE	0
		0
		0
		5,879
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	18,000
		18,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	737
	LABORATORY & XRAY EXPENSE	4,578
	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	4,224
	PHARMACY CONSULTANT XVIII B 39-2	1,485
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	QUALITY CONTROL XVIII B 47-2	2,500
		0
		13,524
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	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
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
	CLERGY	3,480
		3,480
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,400
		0
		2,400
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	85
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	570,373
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	8,090
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	52,850
		0
		60,940
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,229
	EMPLOYEE WANT ADS XIX F	3,710
	CONTRIBUTIONS VI 20 XIX F	750
	DUES & SUBSCRIPTIONS XIX F	6,620
	LICENSES & PERMITS XIX F	1,839
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	16,891
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	250
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	190
	PATIENT BACKGROUND CHECKS XIX F	2,757
		48,236
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	5,190
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	140
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	28,287
	MESSENGER SERVICE	0
		0
		33,617

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	222,844
	UNEMPLOYMENT COMPENSATION XIX D	20,170
	WORKERS COMPENSATION INSURANC XIX D	57,082
	HOSPITALIZATION INSURANCE XIX D	160,351
	EMPLOYEE BENEFITS - OTHER XIX D	3,660
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	501 PLAN EXPENSE XIX D	3,100
	CHICAGO HEAD TAX XIX D	4,160
	UNION PENSION	30,480
		501,847
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	530
		530
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,456
		7,456
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	219,598
		219,598
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,635,128

BIRCHWOOD PLAZA
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	223,556	PATIENT MEALS	161082
LESS SALES TAX	(1,010)	ADD EMPLOYEE MEALS	14600
-----		-----	
NET FOOD	222,546	TOTAL MEALS/YEAR	175682
TOTAL PATIENT CENSUS	53,694	NET FOOD	222546
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	175682
-----		-----	
TOTAL PATIENT MEALS	161082	COST PER MEAL	1.27
		TIME EMPLOYEE MEALS	14600
ADD # EMPLOYEE MEALS/DAY	40	-----	
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	18542
-----		=====	
TOTAL EMPLOYEE MEALS	14600		

BIRCHWOOD PLAZA
 TRANSPORTATION - STAFF
 12/31/2006

ACCT #18370

	NAME	PURPOSE	AMOUNT	AMOUNT	TOTAL

6-Jan	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			323.08
6-Jan	BEE ZEE SERVICE	activities	20.00		
6-Feb	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			323.08
6-Feb	CITI BANK AADVANTAGE	activities	647.21		
6-Feb	PETTY CASH	activities	7.25		
6-Mar	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			323.08
6-Mar	AMER EXPRESS	activities	26.05		
6-Mar	CITI BANK AADVANTAGE	activities	312.58		
6-Apr	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			484.62
6-Apr	CHASE AUTO REFUND	REFUND	-189.15		
6-May	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			323.08
6-May	CITI BANK AADVANTAGE	activities	295.97		
6-May	PETTY CASH	activities	38.75		
6-Jun	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			323.08
6-Jun	CITIBANK AADVANTAGE	activities	244.79		
6-Jun	PETTY CASH	activities	33.64		
6-Jul	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			323.08
6-Jul	K SILVESTRI	activities	396.34		
6-Aug	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			323.08
6-Aug	CITIBANK AADVANTAGE	activities	308.04		
6-Sep	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			323.08
6-Sep	CITIBANK AADVANTAGE	activities	113.12		
6-Sep	MARCEL MERCADO	activities	60.00		
6-Sep	PETTY CASH	activities	8.25		
6-Oct	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			484.62
6-Oct	CITIBANK AADVANTAGE	activities	291.79		
6-Nov	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			323.08
6-Nov	CITIBANK AADVANTAGE	activities	171.25		
6-Nov	PETTY CASH	activities	23.25		
6-Dec	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT			323.08
6-Dec	PETTY CASH	activities	58.25		
6-Dec	CITIBANK AADVANTAGE	activities	157.88		
6-Dec	AMER EXPRESS	activities	49.02		
6-Dec	BEE ZEE SERVICE	activities	31.87		
6-Dec	SABINO TORLO	activities	150.00		

TOTAL			3,256.15	4,200.04	7,456.19
=====					

Facility Name & ID Number **BIRCHWOOD PLAZA**

#0028696

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			2,960	2,960		2,960	115,606	118,566			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			12,899	12,899		12,899	368,514	381,413			32
33	Real Estate Taxes			174,625	174,625		174,625	0	174,625			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(438,000)	0			34
35	Rent-Equipment & Vehicles			2,447	2,447		2,447	0	2,447			35
36	Other (specify):* STORAGE			2,894	2,894		2,894	0	2,894			36
37	TOTAL Ownership			633,825	633,825	0	633,825	46,120	679,945			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		75,038	114,148	189,186		189,186	0	189,186			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			109,500	109,500		109,500	0	109,500			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	75,038	223,648	298,686	0	298,686	0	298,686			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,979,278	512,825	2,492,601	5,984,704	0	5,984,704	14,135	5,998,839			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:

01/01/2006

Ending:

12/31/2006

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	5,837	30		9
10	Interest and Other Investment Income	(7,174)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,010)	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	(250)	20		17
18	Fines and Penalties	(140)	21		18
19	Entertainment				19
20	Contributions	(750)	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	(15,229)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(16,891)	20		28
29	Other-Attach Schedule <u>DEFERRED MAINTENANCE</u>	2,285	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,322)		\$ 0	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	47,457		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 47,457		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 14,135		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 PLAZAID# 0028696Report Period Beginning: 01/01/2006Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 2,285	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	2,285		49

STATE OF ILLINOIS

Summary A

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

01/01/2006

Ending: 12/31/2006

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	(1,010)	0	0	0	0	0	0	0	0	0	0	(1,010)	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	2,285	0	0	0	0	0	0	0	0	0	0	2,285	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,275	0	1,275	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	(33,120)	0	0	0	0	0	0	0	0	0	0	(33,120)	20
21	Clerical & General Office Expenses	(140)	0	0	0	0	0	0	0	0	0	0	(140)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(33,260)	0	(33,260)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(31,985)	0	(31,985)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIRCHWOOD PLAZA# 0028696

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	5,837	109,769	0	0	0	0	0	0	0	0	0	115,606	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,174)	375,688	0	0	0	0	0	0	0	0	0	368,514	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	(1,337)	47,457	0	46,120	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)	(33,322)	47,457	0	14,135	45								

Facility Name & ID Number

BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

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		" "		109,769	109,769	2
3	V	32 INTEREST		" "		375,688	375,688	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			\$ 485,457	\$ * 47,457	14

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

Facility Name & ID Number

BIRCHWOOD PLAZA

#

0028696

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	<u>CHARLOTTE KOHN</u>	<u>EXEC. DIRECTOR</u>	<u>MGMT CONSULT</u>	<u>0.00</u>	<u>62,572</u>	<u>27</u>	<u>45.00</u>	<u>MGMT FEES</u>	<u>\$ 570,373</u>	<u>17-3</u>	<u>1</u>
2											<u>2</u>
3											<u>3</u>
4											<u>4</u>
5											<u>5</u>
6											<u>6</u>
7											<u>7</u>
8											<u>8</u>
9											<u>9</u>
10											<u>10</u>
11											<u>11</u>
12											<u>12</u>
13								TOTAL	\$ 570,373		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: **01/01/2006** Ending: **2/31/2006**

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:

01/01/2006

Ending:

12/31/2006

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	5,519,937	3/5/2009	6.0000	371,141	2						
3	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS		3/1/2004	22,737	10,232			4,547	3						
4	LESS RELATED PARTY INTEREST INCOME											4						
5	HONDA FINANCE		X	AUTO LOAN	\$991.29	4/5/2006	52,657	46,357	4/5/2011	4.9000	2,315	5						
	Working Capital																	
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$13,983.99	6/1/2005	159,817	0	6/1/06	5.0000	4,661	6						
7	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$18,732.58	6/1/2006	224,791	131,128	6/1/07		5,923	7						
8	AMERICAN HONDA		X	AUTO LOAN	\$998.81	10/13/2004	51,662	0	10/27/09	5.9000		8						
9	TOTAL Facility Related				\$77,980.67		\$ 6,511,664	\$ 5,707,654			\$ 388,587	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 6,511,664	\$ 5,707,654			\$ 388,587	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 2005 report.		\$	172,830	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.)		\$	172,865	2
3. Under or (over) accrual (line 2 minus line 1).		\$	35	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	174,590	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	174,625	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	168,516	8
	2002	170,405	9
	2003	167,404	10
	2004	171,122	11
	2005	172,865	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

RELATED PARTY 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 2005 TAX BILL.

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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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>2,655.92</u>	\$ <u>2,655.92</u>
2. <u>11-29-302-012-0000</u>	<u>NURSING HOME</u>	\$ <u>72,752.64</u>	\$ <u>72,752.64</u>
3. <u>11-29-302-020-0000</u>	<u>NURSING HOME</u>	\$ <u>97,456.09</u>	\$ <u>97,456.09</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>172,864.65</u>	\$ <u>172,864.65</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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).

N/A

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>			\$	<u>1</u>
2	<u>NURSING HOME</u>		<u>1984</u>	<u>80,569</u>	<u>2</u>
3	TOTALS			\$ 80,569	3

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

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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 BHF 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	1,297,259	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	2,470	10
11	LOBBY RENOVATION		1984	2,489		40	62	62	1,412	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	2	40	452	450	10,355	14
15	NURSING STATION REMODELLING		1985	7,755		20			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	2,524	18
19	BASEMENT AWNINGS		1985	1,620		15			1,620	19
20	GRAVEL ROOF		1985	2,700		5			2,700	20
21	CEILING BASEMENT NURSING OFFICE		1985	1,200		20			1,200	21
22	ELEVATOR OVERHAUL		1985	12,800		20			12,800	22
23	VARIOUS (ELECTRIC & SPRINKLER)		1986	5,486		20	50	50	5,486	23
24	ELECTRIC PANEL		1988	6,000	190	20	300	110	5,440	24
25	ELECTRICAL IMPROVEMENTS		1990	1,200	38	20	60	22	978	25
26	ELEVATOR IMPROVEMENTS		1990	15,600	495	20	780	285	12,845	26
27	TUCKPOINTING & BRICKWORK		1990	12,300	390	20	615	225	9,667	27
28	LAUNDRY ROOM DUCTWORK		1990	3,000	95	20	150	55	2,370	28
29	BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR		1994	282,054	7,336	20	14,103	6,767	181,941	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	51,755	31
32	ENLARGE PATIENT ROOMS(TRANS TO XI-C 97 AUDIT)		1997	0	149	39	149		1,266	32
33	WINDOWS		1998	41,775	615	25	1,671	1,056	15,039	33
34	SIDING		1998	20,000	513	25	800	287	7,200	34
35	PATIENT ROOM EXHAUST SYSTEM		1998	9,720	486	20	486		3,969	35
36	ELEVATOR SAFETY DEVICES		1998	5,350	357	15	357		2,975	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:

01/01/2006 Ending: 12/31/2006

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	\$ 0	20	\$ 2,493	\$ 2,493	\$ 22,437	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		11,317	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		5,243	39
40	CARPETING / DRAPERIES	2000	5,062	452	7	723	271	4,700	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		1,543	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		1,057	42
43	ELEVATOR UPGRADE / FRONT OUTDOOR WALL SYSTEM	2001	89,217	3,244	27.5	3,244		18,248	43
44	CARPETING	2001	8,264	334	7	1,181	847	6,495	44
45	DRAPERIES	2001	7,753	446	7	1,108	662	5,540	45
46	WALLPAPER / CARPETTING	2002	18,309	1,476	7	2,616	1,140	11,772	46
47	NURSES STATION	2002	15,101	549	27.5	549		2,539	47
48	WALLPAPER / ELEVATOR UPGRADE	2003	13,835	503	27.5	503		1,896	48
49	WALLPAPER / CARPENTRY	2004	46,774	1,701	27.5	1,701		3,681	49
50	WALLPAPER / CARPENTRY / REMODELING	2005	18,014	655	27.5	655		971	50
51	CIRCULATING PUMP	2005	4,139	151	27.5	151		223	51
52	PHONE SYST/WALLPAPER/FLOOR/CARPENTRY/REMODELING	2006	13,703	457	27.5	457		457	52
53	FIRE SUPPRESSION SYST/LIGHT FIXTURES	2006	5,719	130	27.5	130		130	53
54	ELEV DOOR RESTRICTOR/PUMP/SENSORS	2006	6,784	134	27.5	134		134	54
55	GREASE TRAP/PLUMBING/CONCRETE/THRU-WALL A/C'S	2006	12,014	200	27.5	200		200	55
56	NURSING STATION/KITCHEN TILE	2006	14,907	125	27.5	125		125	56
57									57
58									58
59									59
60									60
61									61
62	ADJ TO SL			73,652			(73,652)		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,232,565	\$ 99,496		\$ 99,496	\$ 0	\$ 1,781,663	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	\$ 91,706	\$ 8,676	\$ 8,676	\$ 0	5-15 YRS	\$ 39,010	71
72	Current Year Purchases	2,630	142	142	0	8-15 YRS	142	72
73	Fully Depreciated Assets				0	8-10 YRS		73
74	FROM XI-B (97 AUDIT)	14,550	1,455	1,455	0	10 YRS	13,095	74
75	TOTALS	\$ 108,886	\$ 10,273	\$ 10,273	\$ 0		\$ 52,247	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,	'06 ACURA	2006	\$ 70,375	\$ 2,960	\$ 8,797	\$ 5,837	4 YRS	\$ 8,797	76
77	ADMINISTRATIVE,ETC						0			77
78							0			78
79	FACILITY VAN		1998	13,600			0	4 YRS	13,600	79
80	TOTALS			\$ 83,975	\$ 2,960	\$ 8,797	\$ 5,837		\$ 22,397	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)	\$ 3,505,995	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 112,729	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 118,566	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,837	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,856,307	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: \$ **0** Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMIN,BANKING, /	'01 LEXUS RX300	\$ 815.15	\$ 2,447	17
18	PURCHASING,				18
19	MAINT,ETC				19
20					20
21	TOTAL		\$ 815.15	\$ 2,447	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.	/2007	\$ _____
13.	/2008	\$ _____
14.	/2009	\$ _____

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	\$		\$ 3,710	\$		\$ 3,710	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			502			502	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			109,936			109,936	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				35,826		35,826	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					39,212		39,212	13
14	TOTAL			\$		\$ 114,148	\$ 75,038		\$ 189,186	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 **12/31/2006**

Report Period Beginning: **01/01/2006**
 (last day of reporting year)

Ending: **12/31/2006**

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	\$ 447,430	\$ 496,395	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,615,281	1,615,281	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,377	107,377	6
7	Other Prepaid Expenses	9,254	34,465	7
8	Accounts Receivable (owners or related parties)	5,991	455,991	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,185,333	\$ 2,709,509	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		1,011,243	15
16	Equipment, at Historical Cost	70,375	178,311	16
17	Accumulated Depreciation (book methods)	(2,960)	(2,715,959)	17
18	Deferred Charges		10,232	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	244,955	244,955	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 312,370	\$ 1,041,948	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,497,703	\$ 3,751,457	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 233,188	\$ 233,188	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,888	43,888	28
29	Short-Term Notes Payable	131,128	131,128	29
30	Accrued Salaries Payable	126,009	126,009	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,773	38,773	31
32	Accrued Real Estate Taxes(Sch.IX-B)		174,590	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	201,970	201,970	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 774,956	\$ 949,546	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	46,357	46,357	39
40	Mortgage Payable		5,534,615	40
41	Bonds Payable			41
42	Deferred Compensation	232,236	232,236	42
	Other Long-Term Liabilities(specify):			
43	DUE TO BP ASSOC	764,590	0	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,043,183	\$ 5,813,208	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,818,139	\$ 6,762,754	46
47	TOTAL EQUITY(page 18, line 24)	\$ 679,564	\$ (3,011,297)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,497,703	\$ 3,751,457	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 499,203	1
2	Restatements (describe):		2
3	IL REPL TAX	(18,312)	3
4	ROUNDING	(4)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 480,887	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,280,497	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,081,820)	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)	\$ 198,677	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 679,564	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	\$ 7,111,088	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,111,088	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	159,785	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 159,785	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,284	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,284	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,174	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,174	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,281,331	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	971,983	31
32	Health Care	2,248,073	32
33	General Administration	1,832,137	33
	B. Capital Expense		
34	Ownership	633,825	34
	C. Ancillary Expense		
35	Special Cost Centers	189,186	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	16,130	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,000,834	40
41	Income before Income Taxes (line 30 minus line 40)**	1,280,497	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,280,497	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** 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: 01/01/2006

Ending: 12/31/2006

12/31/2006

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	4,067	4,520	\$ 164,423	\$ 36.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,913	26,422	775,707	29.36	3
4	Licensed Practical Nurses	6,625	7,067	153,884	21.78	4
5	CNAs & Orderlies	66,489	71,609	777,408	10.86	5
6	CNA Trainees					6
7	Licensed Therapist	4,393	4,956	73,976	14.93	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,647	11,156	114,776	10.29	10
11	Social Service Workers	2,431	2,503	45,579	18.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,010	2,315	44,461	19.21	14
15	Cook Helpers/Assistants	7,686	8,687	92,981	10.70	15
16	Dishwashers	8,392	9,114	75,521	8.29	16
17	Maintenance Workers	2,170	2,353	49,295	20.95	17
18	Housekeepers	17,293	19,110	195,185	10.21	18
19	Laundry	3,880	4,327	36,742	8.49	19
20	Administrator	2,083	2,083	199,771	95.91	20
21	Assistant Administrator	1,902	1,902	56,308	29.60	21
22	Other Administrative					22
23	Office Manager	2,168	2,432	45,841	18.85	23
24	Clerical	4,331	4,564	76,145	16.68	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>	64	64	1,275	19.92	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,544	185,184	\$ 2,979,278 *	\$ 16.09	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	\$ 10,277	1-3	35
36	Medical Director	O	18,000	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	1,485	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	2,400	12-3	45
46	Other(specify)	S			46
47	<u>QUALITY CONTROL</u>		2,500	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,886		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	14	\$ 432	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides	20	305	10-3	52
53	TOTAL (lines 50 - 52)	35	\$ 737		53

Facility Name & ID Number **BIRCHWOOD PLAZA**

0028696

Report Period Beginning: **01/01/2006**

Ending: **12/31/2006**

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	ADMINISTRATOR		\$ 199,771	Workers' Compensation Insurance	\$ 57,082	IDPH License Fee	\$	
JOYCE GRODETZ	ASST ADMIN		56,308	Unemployment Compensation Insurance	20,170	Advertising: Employee Recruitment	3,710	
				FICA Taxes	222,844	Health Care Worker Background Check	190	
				Employee Health Insurance	160,351	(Indicate # of checks performed <u>19</u>)		
				Employee Meals	18,542	Patient Background Checks	204 2,757	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,000	
				EMPLOYEE BENEFITS - OTHER	3,660	MARKETING/ADV/PROMO	32,120	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	8,459	
				PENSION/PROFIT SHARING PLANS	3,100			
				CHICAGO HEAD TAX	4,160	TRUST/FRANCHISE/CONTRIB/ETC	(1,000)	
				UNION PENSION	30,480	Less: Public Relations Expense	(0)	
						Non-allowable advertising	(15,229)	
						Yellow page advertising	(16,891)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 256,079	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 520,389		\$ 15,116		
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		\$ 570,373				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)			\$ 570,373				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 \$5,000, attach copy of invoices.)			\$ 60,940	TOTAL		\$	TOTAL	

* 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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	2004	\$ 7,838	3	\$	\$ 1,306	\$ 2,613	\$ 2,613	\$ 1,306	\$	\$	\$
2	PAINT/DECORATING	2005	4,075	3			680	1,358	1,358	679		
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
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: **01/01/2006**Ending: **12/31/2006****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. \$ 0 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. \$ 18,542 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