

Facility Name & ID Number BIRCHWOOD PLAZA

0028696 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	42,446	9,957	3,200	55,603	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,446	9,957	3,200	55,603	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.17%

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 200 and days of care provided 3,200

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number **BIRCHWOOD PLAZA** # **0028696** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	240,610	32,014	10,107	282,731		282,731		282,731		1
2	Food Purchase		289,233		289,233	(23,214)	266,019	(989)	265,030		2
3	Housekeeping	225,763	38,305		264,068		264,068		264,068		3
4	Laundry	59,486	14,828	2,109	76,423		76,423		76,423		4
5	Heat and Other Utilities			119,590	119,590		119,590		119,590		5
6	Maintenance	55,990	22,765	35,161	113,916		113,916		113,916		6
7	Other (specify):*			8,176	8,176		8,176		8,176		7
8	TOTAL General Services	581,849	397,145	175,143	1,154,137	(23,214)	1,130,923	(989)	1,129,934		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,217,555	148,544	8,072	2,374,171		2,374,171		2,374,171		10
10a	Therapy	166,614			166,614		166,614		166,614		10a
11	Activities	132,252	7,513	4,140	143,905		143,905		143,905		11
12	Social Services	7,250		7,150	14,400		14,400		14,400		12
13	CNA Training										13
14	Program Transportation			40	40		40		40		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,523,671	156,057	25,402	2,705,130		2,705,130		2,705,130		16
	C. General Administration										
17	Administrative	259,638		636,747	896,385		896,385		896,385		17
18	Directors Fees										18
19	Professional Services			90,845	90,845		90,845	2,605	93,450		19
20	Dues, Fees, Subscriptions & Promotions			72,084	72,084		72,084	(47,155)	24,929		20
21	Clerical & General Office Expenses	188,581	17,104	36,702	242,387		242,387		242,387		21
22	Employee Benefits & Payroll Taxes			552,869	552,869	23,214	576,083		576,083		22
23	Inservice Training & Education			1,573	1,573		1,573		1,573		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			10,420	10,420		10,420	(3,352)	7,068		25
26	Insurance-Prop.Liab.Malpractice			356,730	356,730		356,730		356,730		26
27	Other (specify):*			12,300	12,300		12,300	(12,300)			27
28	TOTAL General Administration	448,219	17,104	1,770,270	2,235,593	23,214	2,258,807	(60,202)	2,198,605		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,553,739	570,306	1,970,815	6,094,860		6,094,860	(61,191)	6,033,669		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	10,107
	REPAIRS & MAINTENANCE	0
		0
		10,107
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,109
		0
		2,109
5	HEAT & OTHER UTILITIES	
	GAS HEAT	48,502
	ELECTRICITY	54,139
	WATER	15,931
	CABLE TV - LOBBY	1,018
		0
		119,590
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,794
	PAINTING & DECORATING	2,748
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	11,506
	ELEVATOR MAINTENANCE & REPAIR	7,080
	OUTSIDE LABOR	1,995
	EXTERMINATING SERVICE	2,918
	FIRE SERVICE	7,120
		0
		0
		0
		0
		35,161
7	OTHER	
	SCAVENGER	8,176
	SECURITY SERVICE	0
		0
		0
		8,176
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	2,132
	LABORATORY & XRAY EXPENSE	0
	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	4,320
	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
	QUALITY CONTROL	0
		0
		8,072
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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	960
	CLERGY	3,180
		4,140
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	7,150
		0
		7,150
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	40
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	636,747
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	5,536
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	85,309
		0
		90,845
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	16,029
	EMPLOYEE WANT ADS XIX F	17,109
	CONTRIBUTIONS VI 20 XIX F	100
	DUES & SUBSCRIPTIONS XIX F	3,518
	LICENSES & PERMITS XIX F	3,322
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	30,766
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	260
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	380
	PATIENT BACKGROUND CHECKS XIX F	600
		72,084
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	7,032
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	29,670
	MESSENGER SERVICE	0
		0
		36,702

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	264,385
	UNEMPLOYMENT COMPENSATION XIX D	14,697
	WORKERS COMPENSATION INSURANC XIX D	54,336
	HOSPITALIZATION INSURANCE XIX D	191,735
	EMPLOYEE BENEFITS - OTHER XIX D	249
	EMPLOYEE PHYSICAL EXAMS XIX D	277
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	501 PLAN ADJUSTMENT XIX D	(4,102)
	CHICAGO HEAD TAX XIX D	4,896
	UNION PENSION	26,396
		552,869
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,573
		1,573
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,068
	TRANSPORTATION - OTHER	3,352
		10,420
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	356,730
		356,730
27	OTHER	
	BAD DEBTS VI 24	12,300
		12,300

GRAND TOTAL COLUMN 3 OTHER

1,970,815

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			15,760	15,760		15,760	115,571	131,331			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,431	13,431		13,431	322,986	336,417			32
33	Real Estate Taxes			170,058	170,058		170,058		170,058			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(438,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			2,280	2,280		2,280		2,280			36
37	TOTAL Ownership			639,529	639,529		639,529	557	640,086			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		159,433	107,257	266,690		266,690		266,690			39
40	Barber and Beauty Shops			11,488	11,488		11,488		11,488			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		159,433	228,245	387,678		387,678		387,678			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,553,739	729,739	2,838,589	7,122,067		7,122,067	(60,634)	7,061,433			45

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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,081)	30		9
10	Interest and Other Investment Income	(15,736)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(989)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(3,352)	25		16
17	Non-Care Related Fees	(260)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	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	(12,300)	27		24
25	Fund Raising, Advertising and Promotional	(16,029)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(30,766)	20		28
29	Other-Attach Schedule POST-CLOSING LEGAL	2,605	19		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,008)		\$	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)	17,374		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 17,374		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (60,634)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BIRCHWOOD PLAZA

ID# 0028696

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	MYERS MILLER - POST-CLOSING LEGAL	\$	2,605	19
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		2,605	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD PLAZA# 0028696

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(989)	0	0	0	0	0	0	0	0	0	0	(989)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(989)	0	(989)	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	2,605	0	0	0	0	0	0	0	0	0	0	2,605	19
20	Fees, Subscriptions & Promotions	(47,155)	0	0	0	0	0	0	0	0	0	0	(47,155)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(3,352)	0	0	0	0	0	0	0	0	0	0	(3,352)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(12,300)	0	0	0	0	0	0	0	0	0	0	(12,300)	27
28	TOTAL General Administration	(60,202)	0	(60,202)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(61,191)	0	(61,191)	29									

STATE OF ILLINOIS

Facility Name & ID Number BIRCHWOOD PLAZA# 0028696

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,081)	116,652	0	0	0	0	0	0	0	0	0	115,571	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,736)	338,722	0	0	0	0	0	0	0	0	0	322,986	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	(16,817)	17,374	0	557	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(78,008)	17,374	0	0	0	0	0	0	0	0	0	(60,634)	45

Facility Name & ID Number

BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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
		DOBSON PLAZA INC	EVANSTON, IL	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		" "		116,652	116,652	2
3	V	32 INTEREST		" "		338,722	338,722	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			\$ 455,374	\$ * 17,374	14

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

Facility Name & ID Number

BIRCHWOOD PLAZA

#

0028696

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	64,972	27	45.00	MGMT FEES	\$ 636,747	17-3	1
2	BARAK KOHN	DIR OF MAINT	SUPERVISION	0.00	8,604	40	64.00	SALARY	8,557	6-1	2
3	CYNTHIA KOHN	BKKP	BKKP	0.00		15	100.00	SALARY	44,300	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 689,604		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:

01/01/2009

Ending: 2/31/2009

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:

01/01/2009

Ending:

12/31/2009

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		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: MORTGAGE						\$	\$		\$	1						
2	MB FINANCIAL		X	MORTGAGE	\$43,274.00	3/1/2004	6,000,000		3/5/2014	6.0000	308,240						
3	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS		3/1/2004	75,503	23,422			30,482						
4	HARRIS BANK		X	AUTO LOAN	\$962.27	08/12/08	56,140	45,663	08/12/14	7.1900	3,596						
5	LEXUS FINANCIAL		X	AUTO LOAN	\$853.21	06/15/09	44,566	40,731	06/30/14	5.5000	1,284						
	Working Capital																
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$15,436.67	06/01/08	185,240		06/01/09	5.2500	4,567						
7	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$13,744.15	06/01/09	164,930	82,465	06/01/10	4.5000	3,551						
8	BANK		X	LETTER OF CREDIT							433						
9	TOTAL Facility Related				\$74,270.30		\$ 6,526,379	\$ 192,281			\$ 352,153						
	B. Non-Facility Related*																
10	IRS, IDR, ETC		X	LATE FEES													
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 6,526,379	\$ 192,281			\$ 352,153						

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

1. Real Estate Tax accrual used on 2008 report.		\$	178,310	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.)		\$	174,434	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,876)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	176,180	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 \$ 2,246 For *** Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(2,246)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	170,058	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	171,122	8	
	2005	172,865	9	
	2006	174,865	10	
	2007	172,701	11	
	2008	174,434	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
*** REFUND 1998 848.48, REFUND 1999 852.57, REFUND 2000 544.71 TOTAL REFUNDS = 2,245.76				
THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL.				
		FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame STEEL & CONCRETE Number of Stories 3 + BASEMENT

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			\$ <u>80,569</u>	<u>3</u>

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	1,465,160	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	62	62	2,752	10
11	LOBBY RENOVATION	1984		2,489		40	62	62	1,598	11
12	TERRACE RESURFACE	1984		7,600		15			7,600	12
13	FOYER RE-FLOORING	1984		1,835		20			1,835	13
14	BASEMENT RENOVATION	1985		18,061		40	452	452	11,711	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	2,881	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			5,486	23
24	ELECTRIC PANEL	1988		6,000	190	20		(190)	6,000	24
25	ELECTRICAL IMPROVEMENTS	1990		1,200	38	20	60	22	1,158	25
26	ELEVATOR IMPROVEMENTS	1990		15,600	495	20	780	285	15,185	26
27	TUCKPOINTING & BRICKWORK	1990		12,300	390	20	615	225	11,512	27
28	LAUNDRY ROOM DUCTWORK	1990		3,000	95	20	150	55	2,820	28
29	BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR	1994		282,054	7,336	20	14,103	6,767	224,250	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	65,753	31
32	ENLARGE PATIENT ROOMS(TRANS TO XI-C 97 AUDIT)	1997			149	39		(149)		32
33	WINDOWS	1998		41,775	615	25	1,671	1,056	20,052	33
34	SIDING	1998		20,000	513	25	800	287	9,600	34
35	PATIENT ROOM EXHAUST SYSTEM	1998		9,720	486	20	486		5,427	35
36	ELEVATOR SAFETY DEVICES	1998		5,350	357	15	357		4,046	36

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

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

See Page 12A, Line 70 for total

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

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	\$ 29,916	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		15,844	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		7,340	39
40	CARPETING / DRAPERIES	2000	5,062		7			5,062	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		2,242	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		1,621	42
43	ELEVATOR UPGRADE / FRONT OUTDOOR WALL SYSTEM	2001	89,217	3,244	27.5	3,244		27,980	43
44	CARPETING	2001	8,264		7			8,264	44
45	DRAPERIES	2001	7,753		7			7,753	45
46	WALLPAPER / CARPETTING	2002	18,309		7	1,305	1,305	18,309	46
47	NURSES STATION	2002	15,101	549	27.5	549		4,186	47
48	WALLPAPER / ELEVATOR UPGRADE	2003	13,835	503	27.5	503		3,405	48
49	WALLPAPER / CARPENTRY	2004	46,774	1,701	27.5	1,701		8,784	49
50	WALLPAPER / CARPENTRY / REMODELING	2005	18,014	655	27.5	655		2,936	50
51	CIRCULATING PUMP	2005	4,139	151	27.5	151		660	51
52	PHONE SYST/WALLPAPER/FLOOR/CARPENTRY/REMODELING	2006	13,703	498	27.5	498		1,951	52
53	FIRE SUPPRESSION SYST/LIGHT FIXTURES	2006	5,719	208	27.5	208		754	53
54	ELEV DOOR RESTRICTOR/PUMP/SENSORS	2006	6,784	247	27.5	247		875	54
55	GREASE TRAP/PLUMBING/CONCRETE/THRU-WALL A/C'S	2006	12,014	437	27.5	437		1,511	55
56	NURSING STATION/KITCHEN TILE	2006	14,907	542	27.5	542		1,751	56
57	NURSING STATION/FLOORING/LIGHTING/THRU-WALL A/C'S	2007	17,283	628	27.5	628		1,687	57
58	FLOORING/CARPETING/WALLPAPER	2007	20,700	3,974	7	2,957	(1,017)	7,393	58
59	LL OFFICE/BATHRMS/TILE/LOCKS/WIRING/THRU-WALL A/C	2008	45,488	1,654	27.5	1,654		2,368	59
60	CARPETING	2008	2,030	345	7	290	(55)	435	60
61	ROOF	2009	68,700	729	27.5	729		729	61
62	SECURITY SYST/WIRING/CABLE/WALL AC/FLOORING	2009	19,459	297	27.5	297		297	62
63	SECURITY SYST/CABLE/ELECTRIC/OUTLETS/TILE/DRYWALL/TOILETS/SINKS/PAINTING/CARPENTRY								63
64		2009	61,914	282	27.5	282		282	64
65	CARPENTRY/BUILT-INS/MOLDING/TILE/ELECTRIC/CEILING	2009	14,653	22	27.5	22		22	65
66	PAINTING/WALLCOVERING/CARPETING	2009	70,915	41,514	7	5,065	(36,449)	5,889	66
67									67
68	ADJ TO SL			33,971			(33,971)		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,553,707	\$ 107,436		\$ 107,436	\$	\$ 2,093,641	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	\$ 106,203	\$ 8,981	\$ 8,981	\$	5-15 YRS	\$ 62,822	71
72	Current Year Purchases	4,543	235	235		8-15 YRS	235	72
73	Fully Depreciated Assets							73
74	FROM XI-B (97 AUDIT)	14,550				10 YRS	14,550	74
75	TOTALS	\$ 125,296	\$ 9,216	\$ 9,216	\$		\$ 77,607	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,	'09 ACURA	2008	\$ 91,079	\$ 4,800	\$ 9,108	\$ 4,308	10 YRS	\$ 18,216	76
77	ADMINISTRATIVE,ETC	'10 LEXUS	2009	44,566	10,960	5,571	(5,389)	4 YRS	5,571	77
78										78
79	FACILITY VAN		1998	13,600				4 YRS	13,600	79
80	TOTALS			\$ 149,245	\$ 15,760	\$ 14,679	\$ (1,081)		\$ 37,387	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)	\$ 3,908,817	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 132,412	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 131,331	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,081)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,208,635	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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	39-3	hrs	\$		\$ 99,295	\$		\$ 99,295	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			837			837	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			7,125			7,125	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				124,447		124,447	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	RADIOLOGY/LAB/MEDICAL SUPPLIES Other (specify):	39-2					34,986		34,986	13
14	TOTAL			\$		\$ 107,257	\$ 159,433		\$ 266,690	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **BIRCHWOOD PLAZA**# **0028696**Report Period Beginning: **01/01/2009**

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 45,817	1
2	Cash-Patient Deposits	108,900	108,900	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,266,354	1,266,354	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,224	88,224	6
7	Other Prepaid Expenses	6,884	6,884	7
8	Accounts Receivable (owners or related parties)	2,991	2,991	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,473,353	\$ 1,519,170	10
B. Long-Term Assets				
11	Long-Term Notes Receivable		810,000	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		1,333,897	15
16	Equipment, at Historical Cost	135,645	259,991	16
17	Accumulated Depreciation (book methods)	(26,720)	(2,897,612)	17
18	Deferred Charges		23,422	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe DUE FR BP ASSOC)	178,166		22
23	Other(specify): NY LIFE INSUR.CONTRACTS	406,550	406,550	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 693,641	\$ 2,249,414	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,166,994	\$ 3,768,584	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 427,819	\$ 435,360	26
27	Officer's Accounts Payable	194,031	194,031	27
28	Accounts Payable-Patient Deposits	108,900	108,900	28
29	Short-Term Notes Payable	98,619	326,717	29
30	Accrued Salaries Payable	121,602	121,602	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,027	12,027	31
32	Accrued Real Estate Taxes(Sch.IX-B)		176,180	32
33	Accrued Interest Payable			33
34	Deferred Compensation	245,323	245,323	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	DEFERRED INCOME	209,134	209,134	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,417,455	\$ 1,829,274	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	70,240	70,240	39
40	Mortgage Payable		4,728,489	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 70,240	\$ 4,798,729	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,487,695	\$ 6,628,003	46
47	TOTAL EQUITY(page 18, line 24)	\$ 679,299	\$ (2,859,419)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,166,994	\$ 3,768,584	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,503,172	1
2	Restatements (describe):		2
3	2008 IL REPLACEMENT TAX	(34,119)	3
4	ROUNDING	4	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,469,057	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,011,242	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	(1,801,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (789,758)	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)	\$ 679,299	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **BIRCHWOOD PLAZA**

0028696

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	\$ 7,938,323	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,938,323	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,250	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 179,250	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,736	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,736	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)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,133,309	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,154,137	31
32	Health Care	2,705,130	32
33	General Administration	2,235,593	33
B. Capital Expense			
34	Ownership	639,529	34
C. Ancillary Expense			
35	Special Cost Centers	278,178	35
36	Provider Participation Fee	109,500	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,122,067	40
41	Income before Income Taxes (line 30 minus line 40)**	1,011,242	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,011,242	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: **01/01/2009**

Ending:

12/31/2009

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	4,380	4,820	\$ 187,684	\$ 38.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,039	23,147	777,751	33.60	3
4	Licensed Practical Nurses	9,821	10,236	255,392	24.95	4
5	CNAs & Orderlies	76,893	82,361	957,416	11.62	5
6	CNA Trainees					6
7	Licensed Therapist	5,523	6,102	166,614	27.30	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,125	12,730	132,252	10.39	10
11	Social Service Workers	232	232	7,250	31.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,993	2,209	49,766	22.53	14
15	Cook Helpers/Assistants	5,904	6,570	84,442	12.85	15
16	Dishwashers	10,283	11,131	106,402	9.56	16
17	Maintenance Workers	2,396	2,534	55,990	22.10	17
18	Housekeepers	17,984	19,751	225,763	11.43	18
19	Laundry	5,192	5,622	59,486	10.58	19
20	Administrator	2,083	2,083	199,771	95.91	20
21	Assistant Administrator	2,037	2,086	59,867	28.70	21
22	Other Administrative					22
23	Office Manager	3,121	3,210	99,439	30.98	23
24	Clerical	4,816	5,028	89,142	17.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care MDS CLERK	1,222	1,282	39,312	30.66	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	188,044	201,134	\$ 3,553,739 *	\$ 17.67	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	\$ 10,107	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	4,320	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	960	11-3	44
45	Social Service Consultant	E	7,150	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,157		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			10-3	50
51	Licensed Practical Nurses	169	2,027	10-3	51
52	Certified Nurse Assistants/Aides	12	105	10-3	52
53	TOTAL (lines 50 - 52)	181	\$ 2,132		53

Facility Name & ID Number **BIRCHWOOD PLAZA**# **0028696**Report Period Beginning: **01/01/2009** Ending: **12/31/2009****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? YES
If YES, give association name and amount. IL ASSOC H/C FACIL \$2400
- (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. \$ 56,989 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. \$ 23,214 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, 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.