

Facility Name & ID Number BIRCHWOOD PLAZA

0028696 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			4,713	4,713	8
9	SNF/PED					9
10	ICF	43,957	11,233	3,220	58,410	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,957	11,233	7,933	63,123	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.47%

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 4,713

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: 12/31/2014 Fiscal Year: 12/31/2014

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

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	258,342	37,069	9,768	305,179		305,179	305,179		1	
2	Food Purchase		389,043		389,043	(27,740)	361,303	359,762		2	
3	Housekeeping	232,085	71,782		303,867		303,867	303,867		3	
4	Laundry	76,829	19,795	9,755	106,379		106,379	106,379		4	
5	Heat and Other Utilities			158,087	158,087		158,087	158,087		5	
6	Maintenance	83,782	34,903	61,476	180,161		180,161	180,161		6	
7	Other (specify):*			4,854	4,854		4,854	4,854		7	
8	TOTAL General Services	651,038	552,592	243,940	1,447,570	(27,740)	1,419,830	1,418,289		8	
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000	6,000		9	
10	Nursing and Medical Records	2,719,152	208,723	16,875	2,944,750		2,944,750	2,944,750		10	
10a	Therapy	56,549		432	56,981		56,981	56,981		10a	
11	Activities	120,641	9,545	1,150	131,336		131,336	131,336		11	
12	Social Services	29,200		5,875	35,075		35,075	35,075		12	
13	CNA Training									13	
14	Program Transportation			858	858		858	858		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	2,925,542	218,268	31,190	3,175,000		3,175,000	3,175,000		16	
	C. General Administration										
17	Administrative	318,350		1,072,401	1,390,751		1,390,751	408,350		17	
18	Directors Fees									18	
19	Professional Services			130,203	130,203		130,203	122,649		19	
20	Dues, Fees, Subscriptions & Promotions			98,170	98,170		98,170	39,424		20	
21	Clerical & General Office Expenses	280,576	17,525	37,425	335,526		335,526	335,526		21	
22	Employee Benefits & Payroll Taxes			810,221	810,221	27,740	837,961	837,961		22	
23	Inservice Training & Education			2,103	2,103		2,103	2,103		23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation			12,316	12,316		12,316	12,316		25	
26	Insurance-Prop.Liab.Malpractice			89,107	89,107		89,107	89,107		26	
27	Other (specify):*									27	
28	TOTAL General Administration	598,926	17,525	2,251,946	2,868,397	27,740	2,896,137	1,847,436		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,175,506	788,385	2,527,076	7,490,967		7,490,967	6,440,725		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	9,768
	REPAIRS & MAINTENANCE	0
		9,768
3	HOUSEKEEPING	
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	9,755
		9,755
5	HEAT & OTHER UTILITIES	
	GAS HEAT	56,626
	ELECTRICITY	58,434
	WATER	37,553
	CABLE TV - LOBBY	5,474
		158,087
6	MAINTENANCE	
	GROUNDS MAINTENANCE	8,234
	PAINTING & DECORATING	1,123
	BUILDING REPAIRS	4,235
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	23,768
	ELEVATOR MAINTENANCE & REPAIR	13,973
	OUTSIDE LABOR	1,098
	EXTERMINATING SERVICE	2,725
	FIRE SERVICE	6,320
		61,476
7	OTHER	
	SCAVENGER	4,854
	SECURITY SERVICE	0
		4,854
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	1,970
	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	5,000
	PHARMACY CONSULTANT XVIII B 39-2	9,905
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		16,875
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	432
	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
		432
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,150
		1,150
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,375
	CLERGY	1,500
		5,875
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		858
			858
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	1,072,401
			1,072,401
	DIRECTORS FEES		
18	DIRECTORS FEES		0
			0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	57,852
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	72,351
			130,203
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	18,026
	EMPLOYEE WANT ADS	XIX F	36,387
	CONTRIBUTIONS	VI 20 XIX F	2,580
	DUES & SUBSCRIPTIONS	XIX F	1,128
	LICENSES & PERMITS	XIX F	799
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	38,140
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,110
	PATIENT BACKGROUND CHECKS	XIX F	0
			98,170
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,474
	EQUIPMENT REPAIR & MAINTENANCE		10,269
	OUTSIDE CLERICAL SERVICES		3,096
	PENALTIES / OVERDRAFT CHARGES	VI 18	0
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		22,586
	MESSENGER SERVICE		0
			37,425

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	312,698
	UNEMPLOYMENT COMPENSATION	XIX D	18,042
	WORKERS COMPENSATION INSURANC	XIX D	76,194
	HOSPITALIZATION INSURANCE	XIX D	376,039
	EMPLOYEE BENEFITS - OTHER	XIX D	200
	EMPLOYEE PHYSICAL EXAMS	XIX D	720
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	27,118
	LIFE INSURANCE CONTRACTS EXPENS	XIX D	(790)
			810,221
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		2,103
			2,103
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		12,316
			12,316
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		89,107
			89,107
27	OTHER		
	BAD DEBTS	VI 24	0
			0

GRAND TOTAL COLUMN 3 OTHER

2,527,076

**BIRCHWOOD PLAZA
SCHEDULES
12/31/2014**

**EDUCATION & SEMINARS
PAGE 3 V. COLUMN 3 LINE 23**

**TRANSPORTATION - ST
PAGE 3 SCHEDULE V C**

DATE	SPONSOR	PURPOSE OF SEMINAR	PERSONNEL	DEPT	LOC	COST OF SEMINAR	NAME
2/19/2014	ICLTC	FALL PREVENTION WITHOUT RESTRAINTS OR ALARMS	A.SCHIFFMAN C.KOHN J.GRODETZ	ADMIN EXEC DIR ASST ADMIN	IL	495.00	1.14 PAYROLL - ALLC 1.14 CITI 1.14 SAM'S CLUB
2/7,21/2014	FOOD SVC ED	FOODSERVICE MANAGERS CERTIFICATION	Y.MORA	DIETARY	IL	60.00	2.14 PAYROLL - ALLC 2.14 CITI 2.14 AMEX
5/1/2014	ICLTC	INSIDER'S VIEW OF SURVEY PROCESS & OMBUDSMAN PROG	A.SCHIFFMAN C.KOHN	ADMIN EXEC DIR	IL	330.00	2.14 SAM'S CLUB 3.14 PAYROLL - ALLC 3.14 CITI
6/30/2014	ICLTC	INFECTION CONTROL: ARE YOU IN COMPLIANCE?	A.SCHIFFMAN C.KOHN J.GRODETZ	ADMIN EXEC DIR ASST ADMIN	IL	495.00	3.14 AMEX 3.14 SAM'S CLUB 4.14 PAYROLL - ALLC 4.14 CITI
8/31/2014	ICLTC	EMERGENCY PREPAREDNESS: ARE YOU READY?	A.SCHIFFMAN C.KOHN J.GRODETZ	ADMIN EXEC DIR ASST ADMIN	IL	495.00	4.14 AMEX 4.14 SAM'S CLUB 5.14 PAYROLL - ALLC 5.14 CITI
12/11/2014	INR	VIRUSES & GERMS	C.KOHN J.GRODETZ	EXEC DIR ASST ADMIN	IL	228.00	5.14 AMEX 5.14 SAM'S CLUB 6.14 PAYROLL - ALLC 6.14 CITI
						TOTAL	<u>2,103.00</u>
EMPLOYEE MEAL RECLASSIFICATION							
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22							
TOTAL FOOD PURCHASE			389,043				
LESS SALES TAX			<u>(1,541)</u>				
NET FOOD			387,502				
TOTAL PATIENT CENSUS			63,123				
TIMES 3 MEALS PER DAY			<u>3</u>				
TOTAL PATIENT MEALS			189,369				
6.14 AMEX 6.14 SAM'S CLUB 7.14 PAYROLL - ALLC 7.14 CITI 7.14 AMEX 7.14 SAM'S CLUB 8.14 PAYROLL - ALLC 8.14 CITI 9.14 PAYROLL - ALLC 9.14 CITI 9.14 AMEX 9.14 SAM'S CLUB 9.14 P/C							

ADD # EMPLOYEE MEALS/DAY	40
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	<u>14,600</u>
PATIENT MEALS	189,369
ADD EMPLOYEE MEALS	<u>14,600</u>
TOTAL MEALS/YEAR	203,969
NET FOOD	387,502
DIVIDE TOTAL MEALS/YEAR	<u>203,969</u>
COST PER MEAL	1.90
TIMES EMPLOYEE MEALS	<u>14,600</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>27,740</u></u>

- 10.14 PAYROLL - ALLC
- 10.14 CITI
- 10.14 AMEX
- 10.14 SAM'S CLUB
- 11.14 PAYROLL - ALLC
- 11.14 CITI
- 11.14 AMEX
- 11.14 SAM'S CLUB
- 11.14 SEC ST
- 12.14 PAYROLL - ALLC
- 12.14 CITI
- 12.14 AMEX
- 12.14 SAM'S CLUB

TAFF
 COLUMN 3 LINES 25

DESCRIPTION	PURPOSE	AMOUNT	MAINT		TOTAL
			J.GRODET	C.CORIA	
WANCE	banking, maintenance, & activities, transportation		484.62	375.00	
GASOLINE	banking, maintenance, & activities, transportation	278.92			
GASOLINE	banking, maintenance, & activities, transportation	105.02			
WANCE	banking, maintenance, & activities, transportation		323.08	250.00	
GASOLINE	banking, maintenance, & activities, transportation	205.70			
GASOLINE	banking, maintenance, & activities, transportation	56.26			
GASOLINE	banking, maintenance, & activities, transportation	51.38			
WANCE	banking, maintenance, & activities, transportation		323.08	250.00	
GASOLINE	banking, maintenance, & activities, transportation	126.64			
GASOLINE	banking, maintenance, & activities, transportation	28.38			
GASOLINE	banking, maintenance, & activities, transportation	59.37			
WANCE	banking, maintenance, & activities, transportation		323.08	250.00	
GASOLINE	banking, maintenance, & activities, transportation	129.30			
GASOLINE	banking, maintenance, & activities, transportation	72.21			
GASOLINE	banking, maintenance, & activities, transportation	66.39			
WANCE	banking, maintenance, & activities, transportation		323.08	250.00	40.00
GASOLINE	banking, maintenance, & activities, transportation	201.88			
GASOLINE	banking, maintenance, & activities, transportation	50.81			
GASOLINE	banking, maintenance, & activities, transportation	120.22			
WANCE	banking, maintenance, & activities, transportation		323.08	250.00	80.00
GASOLINE	banking, maintenance, & activities, transportation	322.89			
GASOLINE	banking, maintenance, & activities, transportation	23.31			
GASOLINE	banking, maintenance, & activities, transportation	63.29			
WANCE	banking, maintenance, & activities, transportation		323.08	250.00	80.00
GASOLINE	banking, maintenance, & activities, transportation	244.94			
GASOLINE	banking, maintenance, & activities, transportation	7.75			
GASOLINE	banking, maintenance, & activities, transportation	73.08			
WANCE	banking, maintenance, & activities, transportation		484.62	375.00	120.00
GASOLINE	banking, maintenance, & activities, transportation	284.50			
WANCE	banking, maintenance, & activities, transportation		323.08	250.00	120.00
GASOLINE	banking, maintenance, & activities, transportation	117.47			
GASOLINE	banking, maintenance, & activities, transportation	67.40			
GASOLINE	banking, maintenance, & activities, transportation	189.18			
GASOLINE	banking, maintenance, & activities, transportation	2.00			

WANCE	banking, maintenance, & activities, transportation		323.08	250.00	80.00		
GASOLINE	banking, maintenance, & activities, transportation	240.24					
GASOLINE	banking, maintenance, & activities, transportation	7.25					
GASOLINE	banking, maintenance, & activities, transportation	102.43					
WANCE	banking, maintenance, & activities, transportation		323.08	250.00	80.00		
GASOLINE	banking, maintenance, & activities, transportation	203.24					
GASOLINE	banking, maintenance, & activities, transportation	125.08					
GASOLINE	banking, maintenance, & activities, transportation	47.68					
LICENSES		150.00					
WANCE	banking, maintenance, & activities, transportation		323.08	250.00	80.00		
GASOLINE	banking, maintenance, & activities, transportation	124.94					
GASOLINE	banking, maintenance, & activities, transportation	7.75					
GASOLINE	banking, maintenance, & activities, transportation	89.09					
TOTAL			<u>4,045.99</u>	<u>4,200.04</u>	<u>3,250.00</u>	<u>680.00</u>	<u>12,176.03</u>

Facility Name & ID Number **BIRCHWOOD PLAZA**

#0028696

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			1,775	1,775		1,775	146,989	148,764			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,919	2,919		2,919	261,555	264,474			32
33	Real Estate Taxes			201,813	201,813		201,813		201,813			33
34	Rent-Facility & Grounds			936,000	936,000		936,000	(936,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			5,650	5,650		5,650		5,650			36
37	TOTAL Ownership			1,148,157	1,148,157		1,148,157	(527,456)	620,701			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		234,278	661,301	895,579		895,579		895,579			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			465,847	465,847		465,847		465,847			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		234,278	1,127,148	1,361,426		1,361,426		1,361,426			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,175,506	1,022,663	4,802,381	10,000,550		10,000,550	(1,577,698)	8,422,852			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: **01/01/2014**

Ending: **12/31/2014**

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	(1,775)	30		9
10	Interest and Other Investment Income	(40,947)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,541)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,580)	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	(18,026)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(38,140)	20		28
29	Other-Attach Schedule	(989,955)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,092,964)		\$	30

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)	(484,734)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (484,734)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,577,698)		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

BHF USE ONLY						
48		49		50		51
						52

BIRCHWOOD PLAZAID# 0028696Report Period Beginning: 01/01/2014Ending: 12/31/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DISALLOWED LEGAL-CORPORATE MATTERS	\$ (7,554)	19	1
2	DISALLOWED EXCESS MANAGEMENT FEE	(982,401)	17	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		(989,955)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD PLAZA# 0028696

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,541)	0	0	0	0	0	0	0	0	0	0	(1,541)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,541)	0	0	0	0	0	0	0	0	0	0	(1,541)	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	(982,401)	0	0	0	0	0	0	0	0	0	0	(982,401)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,554)	0	0	0	0	0	0	0	0	0	0	(7,554)	19
20	Fees, Subscriptions & Promotions	(58,746)	0	0	0	0	0	0	0	0	0	0	(58,746)	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	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	(1,048,701)	0	0	0	0	0	0	0	0	0	0	(1,048,701)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,050,242)	0	0	0	0	0	0	0	0	0	0	(1,050,242)	29

STATE OF ILLINOIS

Facility Name & ID Number BIRCHWOOD PLAZA# 0028696

Report Period Beginning:

01/01/2014 Ending:

Summary B

12/31/2014

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	(1,775)	148,764	0	0	0	0	0	0	0	0	0	146,989	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(40,947)	302,502	0	0	0	0	0	0	0	0	0	261,555	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(936,000)	0	0	0	0	0	0	0	0	0	(936,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(42,722)	(484,734)	0	(527,456)	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)	(1,092,964)	(484,734)	0	0	0	0	0	0	0	0	0	(1,577,698)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ARTHUR KOHN	75%	DOBSON PLAZA NURSING & REHAB LLC	EVANSTON, IL	BIRCHWOOD PLAZA ASSOCIATES		REAL ESTATE
CHARLOTTE KOHN TRUST	25%				CHICAGO	RENTAL
				CDS LLC		PARKING LOT
					CHICAGO	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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 60,000	CDS LLC		\$	\$ (60,000)	1
2	V	34 RENT	876,000	BIRCHWOOD PLAZA ASSOCIATES			(876,000)	2
3	V	30 SL DEPRECIATION		" "		148,764	148,764	3
4	V	32 INTEREST		" "		302,502	302,502	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		\$ 936,000			\$ 451,266	\$ * (484,734)	14

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 CONSUL	25.00	110,000	27	45.00	MGMT FEES	\$ 90,000	17-3	1
2	BARAK KOHN	DIR OF MAINT	SUPERVISION	0.00	28,577	22	28.00	SALARY	10,953	6-1	2
3	CYNTHIA KOHN	OFFICE MGR	OFFICE MGR	0.00	0	15	100.00	SALARY	54,503	23-1	3
4	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	43,712	6	50.00	SALARY	41,162	17-1	4
5											5
6											6
7											7
8											8
9	BY ATTRIBUTION, 100% KOHN FAMILY OWNED										
10											10
11	CERTAIN AMOUNTS ON THIS PAGE HAVE BEEN ADJUSTED TO REFLECT EXPECTED IL DEPT OF HFS ALLOWABLE LIMITATIONS										
12											12
13								TOTAL	\$ 196,618		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: 01/01/2014

Ending: 2/31/2014

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

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

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

1	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

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 2013 report.		\$	242,140		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.)		\$	242,990		2
3. Under or (over) accrual (line 2 minus line 1).		\$	850		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	245,420		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 \$ 44,457 For *** Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(44,457)		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	201,813		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>155,934</u>	8	FOR BHF USE ONLY	
	2010	<u>162,723</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>162,046</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>239,745</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>242,990</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED					
ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL					
THE PAYMENT ON LINE 2 APPLIES TO THE 2013 TAX BILL.					
*** year 2002=695, 2009=13701, 2010=15400, 2011=14661, TOTAL=44457					

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIRCHWOOD PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028696

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2013 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 2013.

(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>3,767.16</u>	\$ <u>3,767.16</u>
2. <u>11-29-302-012-0000</u>	<u>NURSING HOME</u>	\$ <u>98,351.63</u>	\$ <u>98,351.63</u>
3. <u>11-29-302-020-0000</u>	<u>NURSING HOME</u>	\$ <u>123,185.54</u>	\$ <u>123,185.54</u>
4. <u>11-29-302-016-0000</u>	<u>NURSING HOME PARKING LOT</u>	\$ <u>6,967.62</u>	\$ <u>6,967.62</u>
5. <u>11-29-302-017-0000</u>	<u>NURSING HOME PARKING LOT</u>	\$ <u>5,414.97</u>	\$ <u>5,414.97</u>
6. <u>11-29-302-018-0000</u>	<u>NURSING HOME PARKING LOT</u>	\$ <u>5,302.59</u>	\$ <u>5,302.59</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>242,989.51</u></u>	\$ <u><u>242,989.51</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:

01/01/2014 Ending:

12/31/2014

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RELATED PARTY: B P ASSOC - NURSING HOME</u>		<u>1984</u>	<u>\$ 80,569</u>	1
2	<u>RELATED PARTY: CDS LLC - PARKING LOT</u>		<u>1997</u>	<u>30,081</u>	2
3	TOTALS			\$ 110,650	3

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	1,744,995	5
6										6
7										7
8										8
	Improvement Type**									
9	CONCRETE PAVING & RAILS	1984		13,495		20			13,495	9
10	SPRINKLER MODIFICATION	1984		2,752		25			2,752	10
11	LOBBY RENOVATION	1984		2,489		40	62	62	1,908	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	13,971	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			2,963	18
19	BASEMENT AWNINGS	1985		1,620		15			1,620	19
20	GRAVEL ROOF	1985		2,700		5			2,700	20
21	CEILING BASEMENT NURSING OFFICE	1985		1,200		20			1,200	21
22	ELEVATOR OVERHAUL	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		(38)	1,200	25
26	ELEVATOR IMPROVEMENTS	1990		15,600	495	20		(495)	15,600	26
27	TUCKPOINTING & BRICKWORK	1990		12,300	390	20		(390)	12,300	27
28	LAUNDRY ROOM DUCTWORK	1990		3,000	95	20		(95)	3,000	28
29	BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR	1994		282,054	7,336	20	1,392	(5,944)	282,054	29
30	DRAPERY	1994		7,933		5			7,933	30
31	ROOF & PARKING LOT IMPROVEMENTS	1995		69,984	1,992	15		(1,992)	69,984	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	28,407	33
34	SIDING	1998		20,000	513	25	800	287	13,600	34
35	PATIENT ROOM EXHAUST SYSTEM	1998		9,720	486	20	486		7,981	35
36	ELEVATOR SAFETY DEVICES	1998		5,350	357	15			5,350	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2014 Ending: 12/31/2014

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

1	2	3	4	5	6	7	8	9	10
	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	\$ 42,381	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		23,389	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		10,835	39
40	CARPETING / DRAPERIES	2000	5,062		7			5,062	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		3,407	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		2,561	42
43	ELEVATOR UPGRADE / FRONT OUTDOOR WALL SYSTEM	2001	89,217	3,244	27.5	3,244		44,200	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			18,309	46
47	NURSES STATION	2002	15,101	549	27.5	549		6,931	47
48	WALLPAPER / ELEVATOR UPGRADE	2003	13,835	503	27.5	503		5,920	48
49	WALLPAPER / CARPENTRY	2004	46,774	1,701	27.5	1,701		17,289	49
50	WALLPAPER / CARPENTRY / REMODELING	2005	18,014	655	27.5	655		6,211	50
51	CIRCULATING PUMP	2005	4,139	151	27.5	151		1,415	51
52	PHONE SYST/WALLPAPER/FLOOR/CARPENTRY/REMODELING	2006	13,703	498	27.5	498		4,441	52
53	FIRE SUPPRESSION SYST/LIGHT FIXTURES	2006	5,719	208	27.5	208		1,794	53
54	ELEV DOOR RESTRICTOR/PUMP/SENSORS	2006	6,784	247	27.5	247		2,110	54
55	GREASE TRAP/PLUMBING/CONCRETE/THRU-WALL A/C'S	2006	12,014	437	27.5	437		3,696	55
56	NURSING STATION/KITCHEN TILE	2006	14,907	542	27.5	542		4,461	56
57	NURSING STATION/FLOORING/LIGHTING/THRU-WALL A/C'S	2007	11,968	435	27.5	435		3,401	57
58	FLOORING/CARPETING/WALLPAPER	2007	20,700	1,191	7	1,479	288	20,700	58
59	ACCOUSTICAL WALL TILE/FLOOR TILE	2007	5,315	193	27.5	193		1,426	59
60	LL OFFICE/BATHRMS/TILE/LOCKS/WIRING/THRU-WALL A/C	2008	45,488	1,654	27.5	1,654		10,638	60
61	CARPETING	2008	2,030	115	7	290	175	1,885	61
62	ROOF	2009	68,700	2,498	27.5	2,498		13,219	62
63	SECURITY SYST/WIRING/CABLE/ELECTRIC OUTLETS	2009	57,237	2,082	27.5	2,082		10,833	63
64	TILE/DRYWALL/TOILETS/SINKS/LIGHT FIXTURES/PAINTING/CARPENTRY/WINDOW FRAMES/FLOORING/COVE BASE/THRU-WALL A/C'S								64
65		2009	24,135	877	27.5	877		4,540	65
66	CARPENTRY/BUILT-INS/MOLDING/TILE/ELECTRIC/CEILING	2009	14,653	533	27.5	533		2,687	66
67	PAINTING/WALLCOVERING/CARPETING	2009	70,916	4,387	7	10,131	5,744	55,720	67
68	MIRRORS/CEILING/LIGHT FIXTURES/RAILS/BUMPERS	2010	13,883	505	27.5	505		2,504	68
69	ELEVATOR MOTOR/STARTER	2010	5,680	207	27.5	207		1,026	69
70	TOTAL (lines 4 thru 69)		\$ 3,573,270	\$ 38,697		\$ 95,571	\$ 57,231	\$ 2,634,563	70

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

Facility Name & ID Number BIRCHWOOD PLAZA

0028696

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,573,270	\$ 38,697		\$ 95,571	\$ 56,874	\$ 2,634,563	1
2	FIRE CODE-DAMPERS/DUCTS/SPRINKLERS/WALL EXT/DOOR	2010	45,802	1,665	27.5	1,665		7,701	2
3	BATHROOM TUB/TILES/FIXTURES/PAINTING	2010	18,773	683	27.5	683		3,102	3
4	BUILT-IN WARDROBES/CABINETS/DOORS/COUNTERTOP	2010	37,056	1,347	27.5	1,347		6,118	4
5	TREES/SHRUBS/PERENNIALS/HARDSCAPE/EPOXY STONE	2010	24,949	1,663	15	1,664	1	7,487	5
6	SUMP PUMPS & CONTROL PANEL	2010	12,061	439	27.5	439		1,994	6
7	WALLPAPER/PAINTING/CARPETING/DRAPERIES/CURTAINS	2010	84,560	16,236	7	12,080	(4,156)	54,360	7
8	LIGHT FIXTURES/CIRCUIT PANEL	2010	3,682	134	27.5	134		597	8
9	30 HP COMPRESSOR	2010	15,835	575	27.5	576	1	2,568	9
10	PAINTING/CARPETING/TILE/COVE BASE/DRAPERIES	2010	22,385	4,298	7	3,198	(1,100)	14,391	10
11	OUTSIDE BRICKWORK&WINDOW TRIM/CAULK/TUCKPOINT	2011	11,000	400	27.5	400		1,283	11
12	FIRE DAMPERS	2011	13,620	495	27.5	495		1,547	12
13	CLOSET PROJECT-CARPENTRY/DOORS/ACCESS PANELS	2011	11,094	403	27.5	403		1,259	13
14	PAINTING / 3RD FL DININGROOM CARPENTRY / CHAIR RAILS / WALLPAPER / VINYL FLOORING & GLUE-DOWN CARPETING / WINDOW TREATMENTS / WOOD BLINDS								14
15		2011	22,202	7,105	7	3,172	(3,933)	11,102	15
16	NEW WATER BOILER SYSTEM	2012	126,330	4,593	27.5	4,593		13,589	16
17	BOILER RM/ 3RD FL CLOSET PROJECT/ 2ND FL LIVINGROOM,CAFETERIA,DININGRM-CONCRETE/DRY WALL/CARPENTRY/WALL PREP/PAINTING/WALLPAPER/CHAIRRAILS/								17
18	/FLOORING/TILES/COVE BASE/WINDOW TREATMENTS	2012	24,987	909	27.5	909		2,235	18
19	EAST ELEVATOR JACK/CYLINDER/VALVES/GUIDE SHOE	2012	40,708	1,480	27.5	1,480		3,515	19
20	COMPRESSOR PARTS/PIPING/FIRE DAMPERS	2012	9,490	345	27.5	345		578	20
21	INTERCOM CALL SYSTEM-WIRING,LIGHTS,BOX	2013	6,547	238	27.5	238		398	21
22	DEMOLITION/CONSTRUCTION-ENLARGE LOUNGE AREA	2013	7,103	258	27.5	258		417	22
23	DRILL TAP & 6 PUMP VALVES/COMPRESSOR PARTS	2013	8,820	321	27.5	321		443	23
24	KITCHEN,DISHWASHING AREAS - FLOORING/TILE/COVE BASE/THINSET/GROUT; LAUNDRY AREAS, RESIDENT ROOMS - DRYWALL/WALL PREP/PRIME/PAINT/								24
25	/CARPENTRY/TRIM/STAIN	2013	22,281	810	27.5	810		1,025	25
26	EXTERIOR BRICKWORK/TUCKPOINTING/BLACK TOP	2013	12,722	463	27.5	463		558	26
27	ELEVATOR INFRARED -BEAMED SAFETY EDGE	2014	3,950	90	27.5	90		90	27
28	BUILT-IN STOVE HOOD	2014	4,000	55	27.5	55		55	28
29									29
30									30
31									31
32	ADJUST TO SL			47,687			(47,687)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,163,227	\$ 131,389		\$ 131,389	\$	\$ 2,770,975	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 180,804	\$ 16,837	\$ 16,837	\$	8-15 YRS	\$ 95,554	71
72	Current Year Purchases	8,600	538	538		8 YRS	538	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 189,404	\$ 17,375	\$ 17,375	\$		\$ 96,092	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	BANKING,PURCHASING,	'10 LEXUS	2009	\$ 44,566	\$ 1,775	\$	(1,775)	4 YRS	\$ 44,566	76
77	ADMINISTRATIVE,ETC									77
78										78
79	FACILITY VAN		1998	13,600				4 YRS	13,600	79
80	TOTALS			\$ 58,166	\$ 1,775	\$	(1,775)		\$ 58,166	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,521,447	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 150,539	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 148,764	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,775)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,925,233	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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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			\$	\$ 0	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2014 Ending: 12/31/2014
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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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>
---	---	--

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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	200,439	\$		\$	200,439	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				52,523				52,523	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				408,339				408,339	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					220,084			220,084	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>SUPPLIES/LABS</u>	39-2						14,194			14,194	12
13	Other (specify):											13
14	TOTAL			\$		\$	661,301	\$	234,278	\$	895,579	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: **01/01/2014**

Ending:

12/31/2014**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2014**

(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	\$ 785,555	\$ 790,553	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,976,322	2,976,322	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,474	114,474	6
7	Other Prepaid Expenses	73,970	73,970	7
8	Accounts Receivable (owners or related parties)	228,995	1,038,995	8
9	Other(specify): DUE FROM OTHERS	92,966	92,966	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,272,282	\$ 5,087,280	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		1,930,629	15
16	Equipment, at Historical Cost	44,566	247,570	16
17	Accumulated Depreciation (book methods)	(23,935)	(3,346,506)	17
18	Deferred Charges		61,688	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec REPLACEMENT RESERVE)		3,353,624	22
23	Other(specify): NY LIFE INSUR.CONTRACTS	236,066	236,066	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 256,697	\$ 4,796,237	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,528,979	\$ 9,883,517	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 408,371	\$ 409,871	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		225,000	29
30	Accrued Salaries Payable	199,510	199,510	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,155	19,155	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,860	245,420	32
33	Accrued Interest Payable		12,562	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO BIRCH.PLAZA ASSOC	1,642,918		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,287,814	\$ 1,111,518	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,195,499	40
41	Bonds Payable			41
42	Deferred Compensation	418,293	418,293	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 418,293	\$ 8,613,792	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,706,107	\$ 9,725,310	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,822,872	\$ 158,207	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,528,979	\$ 9,883,517	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,410,027	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,410,027	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,550,868	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	(1,114,565)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>OUT-OF-PERIOD EXPENSES</u>	(23,458)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 412,845	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)	\$ 1,822,872	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,297,617	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,297,617	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	209,924	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 209,924	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	2,930	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)	\$ 2,930	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	40,947	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 40,947	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)	\$ 11,551,418	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,447,570	31
32	Health Care	3,175,000	32
33	General Administration	2,868,397	33
B. Capital Expense			
34	Ownership	1,148,157	34
C. Ancillary Expense			
35	Special Cost Centers	895,579	35
36	Provider Participation Fee	465,847	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,000,550	40
41	Income before Income Taxes (line 30 minus line 40)**	1,550,868	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,550,868	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,904,738	44
45	Private Pay - Net Inpatient Revenue	2,425,480	45
46	Medicare - Net Inpatient Revenue	2,584,556	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	382,843	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,297,617	49

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

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

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

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

Facility Name & ID Number **BIRCHWOOD PLAZA**

0028696

Report Period Beginning: 01/01/2014

Ending:

12/31/2014

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	4,150	4,591	\$ 188,950	\$ 41.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,285	32,255	1,003,450	31.11	3
4	Licensed Practical Nurses	11,650	12,446	324,487	26.07	4
5	CNAs & Orderlies	94,974	101,854	1,125,617	11.05	5
6	CNA Trainees					6
7	Licensed Therapist	3,748	4,115	56,549	13.74	7
8	Rehab/Therapy Aides					8
9	Activity Director	9,206	9,988	120,641	12.08	9
10	Activity Assistants					10
11	Social Service Workers	1,136	1,309	29,200	22.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,107	2,324	56,903	24.48	14
15	Cook Helpers/Assistants	2,138	2,400	34,730	14.47	15
16	Dishwashers	16,310	17,386	166,709	9.59	16
17	Maintenance Workers	3,641	3,911	83,782	21.42	17
18	Housekeepers	17,796	19,444	232,085	11.94	18
19	Laundry	6,041	6,596	76,829	11.65	19
20	Administrator	2,079	2,079	216,321	104.05	20
21	Assistant Administrator	2,085	2,085	60,867	29.19	21
22	Other Administrative	322	322	41,162	127.83	22
23	Office Manager	3,376	3,428	127,439	37.18	23
24	Clerical	8,679	9,098	153,137	16.83	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>	1,889	2,094	76,648	36.60	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	221,612	237,725	\$ 4,175,506 *	\$ 17.56	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	\$ 9,768	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	5,000	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,905	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	1,150	11-3	44
45	Social Service Consultant	E	4,375	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,198		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	131	1,970	10-3	52
53	TOTAL (lines 50 - 52)	131	\$ 1,970		53

Facility Name & ID Number **BIRCHWOOD PLAZA**

0028696

Report Period Beginning: **01/01/2014**

Ending: **12/31/2014**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
ABRAHAM SCHIFFMAN	ADMINISTRATOR		\$ 216,321	Workers' Compensation Insurance	\$ 76,194	IDPH License Fee	\$ 0		
JOYCE GRODETZ	ASST ADMIN		60,867	Unemployment Compensation Insurance	18,042	Advertising: Employee Recruitment	36,387		
REBECCA KOHN	OTHER ADMIN		41,162	FICA Taxes	312,698	Health Care Worker Background Check	1,110		
				Employee Health Insurance	376,039	(Indicate # of checks performed <u>63</u>)			
				Employee Meals	27,740	<u>Patient Background Checks</u>			
				Illinois Municipal Retirement Fund (IMRF)*		<u>TRUST/FRANCHISE/CONTRIB/ETC</u>	2,580		
				<u>EMPLOYEE BENEFITS - OTHER</u>	200	<u>MARKETING/ADV/PROMO</u>	56,166		
				<u>EMPLOYEE PHYSICAL EXAMS</u>	720	<u>LICENSES/DUES/SUBSCRIPTIONS</u>	1,927		
				<u>PENSION/PROFIT SHARING PLANS</u>	27,118				
				<u>CASH VALUE ADJ LIFE INSURANCE</u>	(790)	<u>TRUST/FRANCHISE/CONTRIB/ETC</u>	(2,580)		
				<u>INSURANCE - EXECUTIVE LIFE</u>	0	Less: Public Relations Expense	(0)		
				<u>INSURANCE - EXECUTIVE LIFE VI 21</u>	0	Non-allowable advertising	(18,026)		
						Yellow page advertising	(38,140)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 318,350	TOTAL (agree to Schedule V, line 22, col.8)	\$ 837,961	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 39,424		
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		\$ 90,000				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)			\$ 90,000				Seminar Expense	0	
C. Professional Services				TOTAL			Entertainment Expense		
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
ALPHA DATA	DATA PROCESSING		\$ 6,775	TOTAL		\$			
MATRIX	DATA PROCESSING		51,077						
MYRON TUSHBAI	ACCOUNTING		16,229						
KBKB	ACCOUNTING		20,300						
REIFF SCHRAMM KANTER	REAL ESTATE TAX LEGAL		15,071						
STONE POGRUND & KOREY	LEGAL GUARDIANSHIP		1,556						
POLSINELLI	MEDICAID INTEREST-LEGA		6,707						
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULTI		770						
ADVANTAGE BENEFITS	501A PLAN CONSULTANT		498						
LIFE SAFETY RESOURCES	BUILDING CODE REVIEW		416						
RICHARD PEELO	MEDICARE COST REPORT		3,250						
OTHER LEGAL-CORP MATTERS-DISALLOWED ON PG 5A			7,554						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 130,203						

* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number **BIRCHWOOD PLAZA**# **0028696**Report Period Beginning: **01/01/2014** Ending: **12/31/2014****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. \$ 66,526 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. \$ 465,847
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. \$ 27,740 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.