

Facility Name & ID Number **BIRCHWOOD PLAZA, INC**

0028696

Report Period Beginning: **01/01/18**

Ending: **12/31/18**

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				9
10	Interest and Other Investment Income	(53,681)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,002)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3)	21		18
19	Entertainment				19
20	Contributions	(2,080)	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	(437,267)	27		24
25	Fund Raising, Advertising and Promotional	(33,831)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(39,338)	20		28
29	Other-Attach Schedule SEE PG 5A	(1,072,643)	17		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,640,845)		\$ 0	30

BHF USE ONLY							
48		49		50		51	

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)	(612,897)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (612,897)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,253,742)		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, INC

ID# 0028696

Report Period Beginning: 01/01/18

Ending: 12/31/18

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	DISALLOWED EXCESS MANAGEMENT FEE	\$ (1,072,643)	17	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,072,643)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD PLAZA, INC# 0028696

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	(2,002)	0	0	0	0	0	0	0	0	0	0	(2,002)	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	(2,002)	0	0	0	0	0	0	0	0	0	0	(2,002)	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	(1,072,643)	0	0	0	0	0	0	0	0	0	0	(1,072,643)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(75,249)	0	0	0	0	0	0	0	0	0	0	(75,249)	20
21	Clerical & General Office Expenses	(3)	0	0	0	0	0	0	0	0	0	0	(3)	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):*	(437,267)	0	0	0	0	0	0	0	0	0	0	(437,267)	27
28	TOTAL General Administration	(1,585,162)	0	0	0	0	0	0	0	0	0	0	(1,585,162)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,587,164)	0	0	0	0	0	0	0	0	0	0	(1,587,164)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **BIRCHWOOD PLAZA, INC**

0028696

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	0	78,863	0	0	0	0	0	0	0	0	0	78,863 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(53,681)	244,240	0	0	0	0	0	0	0	0	0	190,559 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	(53,681)	(612,897)	0	(666,578) 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,640,845)	(612,897)	0	(2,253,742) 45								

Facility Name & ID Number BIRCHWOOD PLAZA, INC

0028696

Report Period Beginning: 01/01/18 Ending: 12/31/18

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
						PARKING LOT
				CDS LLC	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							2
3	V	34 RENT	876,000	BIRCHWOOD PLAZA ASSOCIATES			(876,000)	3
4	V	30 SL DEPRECIATION		" "		78,863	78,863	4
5	V	32 INTEREST		" "		244,240	244,240	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			\$ 323,103	\$ * (612,897)	14

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

Facility Name & ID Number BIRCHWOOD PLAZA, INC # 0028696 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	25.00	110,000	27	45.00	MGMT FEES	\$ 90,000	17-3	1
2	BARAK KOHN	DIR OF MAINT	SUPERVISION	0.00	28,500	12	40.00	SALARY	10,625	6-1	2
3	CYNTHIA KOHN	OFFICE MGR	OFFICE MGR	0.00	47,504	26	13.00	SALARY	57,000	21-1	3
4	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	58,400	6	50.00	SALARY	53,400	17-1	4
5											5
6											6
7											7
8											8
9	BY ATTRIBUTION, 100% KOHN FAMILY OWNED										9
10											10
11	CERTAIN AMOUNTS ON THIS PAGE HAVE BEEN ADJUSTED TO REFLECT EXPECTED IL DEPT OF HFS ALLOWABLE LIMITATIONS										11
12											12
13								TOTAL	\$ 211,025		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, INC

0028696

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	RELATED PARTY - BIRCHWOOD PLAZA ASSOCIATES: MORTGAGE						\$	\$			\$	1						
2	CIBC BANK		X	MORTGAGE - RENEWED	\$16,667+INT	3/14/2017		9,000,000	6,687,867	3/14/2022	5.2500	235,245	2					
3	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS				44,974	28,858			8,995	3					
4													4					
5													5					
Working Capital																		
6	CIBC BANK		X	LINE OF CREDIT						3/11/2020		5,233	6					
7													7					
8													8					
9	TOTAL Facility Related						\$	9,044,974	\$ 6,716,725			\$ 249,473	9					
B. Non-Facility Related*																		
10													10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	0	\$ 0			\$ 0	14					
15	TOTALS (line 9+line14)						\$	9,044,974	\$ 6,716,725			\$ 249,473	15					

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

Facility Name & ID Number **BIRCHWOOD PLAZA, INC**

0028696 Report Period Beginning: **01/01/18** Ending: **12/31/18**

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 2017 report.			\$	278,550 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.)			\$	296,419 2
3.	Under or (over) accrual (line 2 minus line 1).			\$	17,869 3
4.	Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	299,380 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.)			\$	18,296 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 \$ 46,555 For ** Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(46,555) 6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	288,990 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2013	242,990	8		
	2014	247,884	9		
	2015	252,323	10		
	2016	275,790	11		
	2017	296,419	12		
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~101% OF THE PRIOR YEAR REAL ESTATE TAX BILL - THE PAYMENT ON LINE 2 APPLIES TO THE 2017 TAX BILL.					
** 2004,2013,2014 R/E/TX REFUNDS 46,555 NET OF LEGAL 18,296 = 31,019					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2017 \$ 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIRCHWOOD PLAZA, INC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028696

CONTACT PERSON REGARDING THIS REPORT _____

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 2017 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 2017.

	(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>4,443.38</u>	\$ <u>4,443.38</u>
2.	<u>11-29-302-012-0000</u>	<u>NURSING HOME</u>	\$ <u>120,383.16</u>	\$ <u>120,383.16</u>
3.	<u>11-29-302-020-0000</u>	<u>NURSING HOME</u>	\$ <u>150,659.78</u>	\$ <u>150,659.78</u>
4.	<u>11-29-302-016-0000</u>	<u>PARKING LOT</u>	\$ <u>8,246.98</u>	\$ <u>8,246.98</u>
5.	<u>11-29-302-017-0000</u>	<u>PARKING LOT</u>	\$ <u>6,409.19</u>	\$ <u>6,409.19</u>
6.	<u>11-29-302-018-0000</u>	<u>PARKING LOT</u>	\$ <u>6,276.23</u>	\$ <u>6,276.23</u>
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>296,418.72</u>	\$ <u>296,418.72</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,825 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>B P ASSOC - NURSING HOME</u>	<u>27,609</u>	<u>1984</u>	<u>\$ 80,569</u>	<u>1</u>
2	<u>CDS LLC - PARKING LOT</u>	<u>23,854</u>	<u>1997</u>	<u>30,081</u>	<u>2</u>
3	TOTALS	51,463		\$ 110,650	3

Facility Name & ID Number BIRCHWOOD PLAZA, INC# 0028696

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	1,968,863	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	2,156	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	15,779	14
15		NURSING STATION REMODELLING	per audit -7,755	1985	0		20				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	per audit -12,800	1985	0		20				22
23		VARIOUS (ELECTRIC & SPRINKLER)		1986	5,486		20			5,486	23
24		ELECTRIC PANEL		1988	6,000		20			6,000	24
25		ELECTRICAL IMPROVEMENTS		1990	1,200		20			1,200	25
26		ELEVATOR IMPROVEMENTS		1990	15,600		20			15,600	26
27		TUCKPOINTING & BRICKWORK		1990	12,300		20			12,300	27
28		LAUNDRY ROOM DUCTWORK		1990	3,000		20			3,000	28
29		BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR		1994	282,054		20			282,054	29
30		DRAPERY		1994	7,933		5			7,933	30
31		ROOF & PARKING LOT IMPROVEMENTS	per audit -36,500	1995	33,484		15			33,484	31
32		ENLARGE PATIENT ROOMS(TRANS TO XI-C 97 AUDIT)		1997	0	149	39		(149)		32
33		WINDOWS		1998	41,775	615	25	1,671	1,056	35,091	33
34		SIDING		1998	20,000	513	25	800	287	16,800	34
35		PATIENT ROOM EXHAUST SYSTEM		1998	9,720	281	20	281		9,720	35
36		ELEVATOR SAFETY DEVICES		1998	5,350	357	15			5,350	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number BIRCHWOOD PLAZA, INC# 0028696

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	1	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	\$	\$	\$ 49,866	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		29,425	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		13,631	39
40	CARPETING / DRAPERIES	2000	5,062		7			5,062	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		4,339	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		3,313	42
43	ELEV UPGRADE/FRONT OUTDOOR WALL SYST per audit -1,016	2001	88,201	3,244	27.5	3,244		57,176	43
44	CARPETING	2001	8,264		7			8,264	44
45	DRAPERIES per audit -7,753	2001	0		7				45
46	WALLPAPER / CARPETING per audit -18,309	2002	0		7			0	46
47	NURSES STATION	2002	15,101	549	27.5	549		8,898	47
48	WALLPAPER / ELEVATOR UPGRADE per audit -13,835	2003	0	503	27.5	503		7,932	48
49	WALLPAPER / CARPENTRY	2004	46,774	1,701	27.5	1,701		24,093	49
50	WALLPAPER / CARPENTRY / REMODELING	2005	18,014	655	27.5	655		8,831	50
51	CIRCULATING PUMP	2005	4,139	150	27.5	150		2,014	51
52	PHONE SYST/WALLPAPER/FLOOR/CARPENTRY/REMODELING	2006	13,703	498	27.5	498		6,433	52
53	FIRE SUPPRESSION SYST/LIGHT FIXTURES	2006	5,719	208	27.5	208		2,626	53
54	ELEV DOOR RESTRICTOR/PUMP/SENSORS	2006	6,784	247	27.5	247		3,098	54
55	GREASE TRAP/PLUMBING/CONCRETE/THRU-WALL A/C'S	2006	12,014	437	27.5	437		5,444	55
56	NURSING STATION/KITCHEN TILE	2006	14,907	542	27.5	542		6,629	56
57	NURSING STATION/FLOORING/LIGHTING/THRU-WALL A/C'S	2007	11,968	435	27.5	435		5,141	57
58	FLOORING/CARPETING/WALLPAPER	2007	20,700		7			20,700	58
59	ACCOUSTICAL WALL TILE/FLOOR TILE	2007	5,315	193	27.5	193		2,198	59
60	LL OFFICE/BATHRMS/TILE/LOCKS/WIRING/THRU-WALL A/C	2008	45,488	1,654	27.5	1,654		17,254	60
61	CARPETING per audit -2,030	2008	0		7				61
62	ROOF	2009	68,700	2,498	27.5	2,498		23,211	62
63	SECURITY SYST/WIRING/CABLE/OUTLETS per audit -7,500	2009	49,737	2,082	27.5	2,082		19,161	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		8,048	65
66	CARPENTRY/BUILT-INS/MOLDING/TILE/ELECTRIC/CEILING	2009	14,653	533	27.5	533		4,820	66
67	PAINTING/WALLCOVERING/CARPETING	2009	70,916		7			70,916	67
68	MIRRORS/CEILING/LIGHT FIXTURES/RAILS/BUMPERS	2010	13,883	505	27.5	505		4,524	68
69	ELEVATOR MOTOR/STARTER	2010	5,680	207	27.5	207		1,854	69
70	TOTAL (lines 4 thru 69)		\$ 3,465,772	\$ 22,262		\$ 79,580	\$ 57,675	\$ 2,890,948	70

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

Facility Name & ID Number BIRCHWOOD PLAZA, INC# 0028696

Report Period Beginning:

01/01/18

Ending:

12/31/18

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		\$ 3,465,772	\$ 22,262		\$ 79,580	\$ 57,318	\$ 2,890,948	1
2	FIRE CODE-DAMPERS/DUCTS/SPRINKLERS/WALL EXT/DOOR	2010	45,802	1,665	27.5	1,665		14,361	2
3	BATHROOM TUB/TILES/FIXTURES/PAINTING	2010	18,773	683	27.5	683		5,834	3
4	BUILT-IN WARDROBES/CABINETS/DOORS/COUNTERTOP	2010	37,056	1,347	27.5	1,347		11,506	4
5	TREES/SHRUBS/PERENNIALS/HARDSCAPE/EPOXY STONE	2010	24,949	1,664	15	1,664		14,142	5
6	SUMP PUMPS & CONTROL PANEL	2010	12,061	439	27.5	439		3,750	6
7	WALLPAPER/PAINTING/CARPETING/DRAPERIES/CURTAINS	2010	84,560		7			84,560	7
8	LIGHT FIXTURES/CIRCUIT PANEL	2010	3,682	134	27.5	134		1,133	8
9	30 HP COMPRESSOR	2010	15,835	575	27.5	576	1	4,871	9
10	PAINTING/CARPETING/TILE/COVE BASE/DRAPERIES	2010	22,385		7			22,385	10
11	OUTSIDE BRICKWORK&WINDOW TRIM/CAULK/TUCKPOINT	2011	11,000	400	27.5	400		2,883	11
12	FIRE DAMPERS	2011	13,620	495	27.5	495		3,527	12
13	CLOSET PROJECT-CARPENTRY/DOORS/ACCESS PANELS	2011	11,094	403	27.5	403		2,871	13
14	PAINTING / 3RD FL DININGROOM CARPENTRY / CHAIR RAILS / WALLPAPER / VINYL FLOORING & GLUE-DOWN CARPETING / WINDOW TREATMENTS								14
15		2011	22,202		7	1,584	1,584	22,202	15
16	3 BOILERS HEATING & 2 BOILERS WATER	2011	126,330	4,593	27.5	4,593		31,961	16
17	BOILER RM/ 3RD FL CLOSET PROJECT/ 2ND FL LIVINGROOM,CAFETERIA,DININGRM-CONCRETE/DRYWALL/CARPENTRY/WALL PREP/PAINTING/WAL								17
18	/FLOORING/TILES/COVE BASE/WINDOW TREATMENTS	2012	24,987	909	27.5	909		5,871	18
19	EAST ELEVATOR JACK/CYLINDER/VALVES/GUIDE SHOE	2012	40,708	1,480	27.5	1,480		9,435	19
20	COMPRESSOR PARTS/PIPING/FIRE DAMPERS	2012	9,490	345	27.5	345		1,958	20
21	Intercom call system-wiring, lights, box throughout building	2013	6,547	238	27.5	238		1,350	21
22	Demolition & re-construction 1st & 2nd fl to enlarge lounge area	2013	7,103	258	27.5	258		1,449	22
23	Drill tap & 6 pump valves for compressor system	2013	8,820	321	27.5	321		1,727	23
24	Kitchen,dishwashing areas - flooring/tile/cove base/thinset/grout; laundry areas; resident rooms 111 & 307-drywall/wall prep/prime/paint								24
25	/carpentry/trim/stain per audit -2189	2013	20,092	810	27.5	810		4,265	25
26	Exterior brickwork/tuckpointing/blacktop	2013	12,722	463	27.5	463		2,410	26
27	Install infrared elevator beamed safety edge system	2014	3,950	144	27.5	144		666	27
28	Built-in kitchen stove hood	2014	4,000	145	27.5	145		635	28
29	Level 2nd floor diningroom cement floor	2015	2,767	101	27.5	101		324	29
30	Install concrete pad behind building for new generator	2015	8,000	291	27.5	291		909	30
31	Install 4" gas line & valves for new generator	2015	8,325	303	27.5	303		922	31
32	85KW gas generator, design fee,2" gas line, fence surround	2016	112,884	4,104	27.5	4,104		11,458	32
33	Replace cylinder on west passenger elevator	2016	38,900	1,414	27.5	1,414		3,712	33
34	TOTAL (lines 1 thru 33)		\$ 4,224,416	\$ 45,986		\$ 104,889	\$ 58,903	\$ 3,164,025	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,224,416	\$ 45,986		\$ 104,889	\$ 58,903	\$ 3,164,025	1
2	New flat roof protective coating	2016	4,974	181	27.5	181		460	2
3	Replace vinyl tile & cove base in resident rooms 104/106/127	2016	9,952	362	27.5	362		860	3
4	Install 12 outlets & 2 fuse boxes	2016	21,000	764	27.5	764		1,624	4
5	Replace west elevator valve	2016	6,250	227	27.5	227		464	5
6	Electrical wiring for uprades to fire alarm system connections								6
7	to both elevators & generator	2017	9,775	355	27.5	355		518	7
8	Carpeting	2018	13,853	1,484	7	1,484		1,484	8
9	New pump unit for east elevator	2018	7,500	102	27.5	102		102	9
10	16 Electrical & lighting units	2018	5,200	39	27.5	39		39	10
11									11
12									12
13									13
14									14
15									15
16									16
17	ADJUST TO SL			58,903			(58,903)		17
18									18
19	CAPITAL COST REPORT AUDIT ADJUSTMENTS		109,686						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	TOTAL (lines 1 thru 33)		\$ 4,412,606	\$ 108,403		\$ 108,403	\$ 0	\$ 3,169,576	34

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

Facility Name & ID Number **BIRCHWOOD PLAZA, INC**

0028696

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	\$ 193,762	\$ 16,717	\$ 16,717	\$ 0	8-15 yrs	\$ 143,402	71
72	Current Year Purchases	8,447	1,056	1,056	0	8-10 yrs	1,056	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 202,209	\$ 17,773	\$ 17,773	\$ 0		\$ 144,458	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	\$ 0	\$ (1,775)	4 YRS	\$ 44,566	76
77	ADMINISTRATIVE,ETC						0			77
78							0			78
79	FACILITY VAN		1998	13,600	0	0	0	4 YRS	13,600	79
80	TOTALS			\$ 58,166	\$ 1,775	\$ 0	\$ (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)	\$ 4,783,631	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 127,951	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 126,176	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)	\$ 3,372,200	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A-RELATED PARTY**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **0** Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	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. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Units of Service	Cost	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
						Units	Cost					
1	Licensed Occupational Therapist	10a-1	3930	hrs	\$ 194,374					3,930	\$ 194,374	1
2	Licensed Speech and Language Development Therapist	10a-1	927	hrs	46,367				530	927	46,897	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10a-1	4182	hrs	194,020					4,182	194,020	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					89,397		89,397	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Other (specify):											12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2							12,665		12,665	13
14	TOTAL				\$ 434,761		\$	\$ 102,592		9,039	\$ 537,353	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, INC**# **0028696**Report Period Beginning: **01/01/18**Ending: **12/31/18**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/18**

(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	\$ 1,494,140	\$ 1,497,862	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	975,250	975,250	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	518,624	518,624	6
7	Other Prepaid Expenses	1,545	1,545	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM OTHERS	106,948	916,948	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,096,507	\$ 3,910,229	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		2,180,009	15
16	Equipment, at Historical Cost	44,566	262,290	16
17	Accumulated Depreciation (book methods)	(31,035)	(3,603,905)	17
18	Deferred Charges		28,858	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)		2,543,333	22
23	Other(specify): LIFE INSUR. CONTRACTS	197,685	197,685	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 211,216	\$ 3,921,436	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,307,723	\$ 7,831,665	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 378,940	\$ 378,940	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,480	100,480	29
30	Accrued Salaries Payable	109,100	109,100	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,408	34,408	31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,140	299,380	32
33	Accrued Interest Payable	300	20,017	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO BIRCHWD PLAZA ASSOC	1,958,026	(10,780)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,602,394	\$ 931,545	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,687,867	40
41	Bonds Payable			41
42	Deferred Compensation	452,237	452,237	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 452,237	\$ 7,140,104	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,054,631	\$ 8,071,649	46
47	TOTAL EQUITY(page 18, line 24)	\$ 253,092	\$ (239,984)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,307,723	\$ 7,831,665	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 683,155	1
2	Restatements (describe):		2
3	2017 IL REPLACEMENT TAX	(20,534)	3
4	PRIOR YEAR ADJ	(1,185)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 661,436	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	861,207	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	(1,240,865)	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)	\$ (379,658)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 281,778	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **BIRCHWOOD PLAZA, INC**# **0028696**Report Period Beginning: **01/01/18**Ending: **12/31/18****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	\$ 11,263,100	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,263,100	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	363,339	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 363,339	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	823	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)	\$ 823	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	53,681	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 53,681	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	4,353	27
28	OTHER EXPENSE ADJUSTMENTS	63,695	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 68,048	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,748,991	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,571,538	31
32	Health Care	3,991,364	32
33	General Administration	3,610,982	33
B. Capital Expense			
34	Ownership	1,218,603	34
C. Ancillary Expense			
35	Special Cost Centers	537,353	35
36	Provider Participation Fee	429,753	36
D. Other Expenses (specify):			
37	W/O BAD DEBTS	(471,809)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,887,784	40
41	Income before Income Taxes (line 30 minus line 40)**	861,207	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 861,207	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,683,785	44
45	Private Pay - Net Inpatient Revenue	2,198,609	45
46	Medicare - Net Inpatient Revenue	1,975,866	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	404,840	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,263,100	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, INC**# **0028696**

Report Period Beginning:

01/01/18

Ending:

12/31/18**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	1,981	2,126	\$ 98,109	\$ 46.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,833	29,529	961,528	32.56	3
4	Licensed Practical Nurses	11,668	12,670	353,581	27.91	4
5	CNAs & Orderlies	89,074	96,616	1,305,123	13.51	5
6	CNA Trainees					6
7	Licensed Therapist	9,030	9,039	460,160	50.91	7
8	Rehab/Therapy Aides	688	688	25,399	36.92	8
9	Activity Director	2,065	2,353	52,154	22.16	9
10	Activity Assistants	12,050	12,997	181,271	13.95	10
11	Social Service Workers	2,007	2,194	74,614	34.01	11
12	Dietician					12
13	Food Service Supervisor	465	465	22,096	47.52	13
14	Head Cook	2,056	2,280	59,718	26.19	14
15	Cook Helpers/Assistants	1,945	2,199	34,646	15.76	15
16	Dishwashers	15,250	16,498	205,676	12.47	16
17	Maintenance Workers	4,420	4,801	115,907	24.14	17
18	Housekeepers	17,497	19,272	264,030	13.70	18
19	Laundry	5,963	6,624	90,982	13.74	19
20	Administrator	2,085	2,085	237,018	113.68	20
21	Assistant Administrator	1,314	1,314	36,780	27.99	21
22	Other Administrative	1,604	1,604	53,533	33.37	22
23	Office Manager	5,366	5,591	194,861	34.85	23
24	Clerical	1,990	2,024	52,948	26.16	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	1,791	1,911	72,602	37.99	31
32	Other Health C: RN Rehab Directo	2,104	2,377	107,460	45.21	32
33	Other(specify) <u>QA</u>	423	497	35,751	71.93	33
34	TOTAL (lines 1 - 33)	219,669	237,754	\$ 5,095,947 *	\$ 21.43	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	\$ 9,288	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	4,800	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,115	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	1,000	11-3	44
45	Social Service Consultant	E	5,630	12-3	45
46	Other(specify)	S			46
47	<u>CLERGY</u>		1,100	11-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,933		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 350	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$ 350		53

BIRCHWOOD PLAZA, INC
LEGAL EXPENSES
12/31/18

DATE	FIRM	INVOICE #	PURPOSE	TOTAL
6/4/2018	CLARK HILL	90418	LEGAL GUARDIANSHIP ISSUES	1,000
11/29/2018	CLARK HILL	827507	LEGAL GUARDIANSHIP ISSUES	1,650
12/13/2018	CLARK HILL	834180	LEGAL GUARDIANSHIP ISSUES	375
12/31/2018	CLARK HILL		LEGAL GUARDIANSHIP ISSUES	3,951
4/30/2018	STONE POGRUND KOREY	92276	LEGAL GUARDIANSHIP ISSUES	886
6/30/2018	STONE POGRUND KOREY	94202	LEGAL GUARDIANSHIP ISSUES	220
7/31/2018	STONE POGRUND KOREY	95338	LEGAL GUARDIANSHIP ISSUES	142
8/31/2018	STONE POGRUND KOREY	96453	LEGAL GUARDIANSHIP ISSUES	50
9/30/2018	STONE POGRUND KOREY	97441	LEGAL GUARDIANSHIP ISSUES	17
11/30/2018	STONE POGRUND KOREY	99845	LEGAL GUARDIANSHIP ISSUES	75
12/31/2018	STONE POGRUND KOREY	100997	LEGAL GUARDIANSHIP ISSUES	745
4/9/2018	MCCABE KIRSHNER	1942	ABK CONSULTING - 2567 REPORT	188
			TOTAL	<u><u>9,299</u></u>

Facility Name & ID Number BIRCHWOOD PLAZA, INC# 0028696Report Period Beginning: 01/01/18Ending: 12/31/18**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?
If YES, give association name and amount. NO
- (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?
What was the average life used for new equipment added during this period? YES
10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 77,323 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. \$ 429,753
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. \$ 29,638 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.