

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0028696</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Birchwood Plaza</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>1426 West Birchwood</u> <u>Chicago</u> <u>60626</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>773-274-4405</u> Fax # <u>847-570-0112</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>06/17/84</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Mendel S Schneider</u>			
Telephone Number: <u>847-933-1274</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		Paid Preparer	
		(Signed) <u>See Accountant's Report Attached</u> (Date) _____	
		(Print Name and Title) _____	
		(Firm Name & Address) <u>Mendel S Schneider & Associates CPA PC</u>	
		<u>4051 Old Orchard Rd Skokie Illinois 60076</u>	
		(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	

Facility Name & ID Number

Birchwood Plaza

#

0028696

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9		
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other		Total
				Medicaid Primary	Medicare Primary					
8	SNF	12,651	30,632	76	180	7,452	2,769		53,760	
9	SNF/PED									
10	ICF									
11	ICF/DD									
12	SC									
13	DD 16 OR LESS									
14	TOTALS	12,651	30,632	76	180	7,452	2,769		53,760	

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

73.64%

D. How many bed reserve days during this year were paid by the Department?

0

(Do not include bed reserve 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

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

06/17/84

J. Was the facility purchased or leased after January 1, 1978?

YES

Date

06/17/84

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter certified beds.

number of certified beds

200

Medicare Intermediary

Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31

Fiscal Year:

12/31

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

Facility Name & ID Number **Birchwood Plaza** # **0028696** Report Period Beginning: **01/01/2025** Ending: **12/31/2025**

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	405,803	42,403	5,472	453,678		453,678		453,678			1
2	Food Purchase		559,105		559,105		559,105	(1,334)	557,771			2
3	Housekeeping	372,980	22,799	40,231	436,010		436,010		436,010			3
4	Laundry	151,507	15,557		167,064		167,064		167,064			4
5	Heat and Other Utilities			199,306	199,306		199,306		199,306			5
6	Maintenance	160,400		108,854	269,254		269,254		269,254			6
7	Other (specify):*											7
8	TOTAL General Services	1,090,690	639,864	353,863	2,084,417		2,084,417	(1,334)	2,083,083			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	5,067,562	288,414	97,537	5,453,513		5,453,513		5,453,513			10
10a	Therapy	368,265			368,265		368,265		368,265			10a
11	Activities	191,013			191,013		191,013		191,013			11
12	Social Services	238,908	9,484		248,392		248,392		248,392			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,865,748	297,898	103,537	6,267,183		6,267,183		6,267,183			16
	C. General Administration											
17	Administrative	205,413		593,664	799,077		799,077		799,077			17
18	Directors Fees											18
19	Professional Services			440,447	440,447		440,447	(300,000)	140,447			19
20	Dues, Fees, Subscriptions & Promotions			27,377	27,377		27,377	(18,914)	8,463			20
21	Clerical & General Office Expenses	550,804	85,238	206,090	842,132		842,132	(19,774)	822,358			21
22	Employee Benefits & Payroll Taxes			1,365,650	1,365,650		1,365,650		1,365,650			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			18,485	18,485		18,485	(18,485)				25
26	Insurance-Prop.Liab.Malpractice			477,886	477,886		477,886		477,886			26
27	Other (specify):*											27
28	TOTAL General Administration	756,217	85,238	3,129,599	3,971,054		3,971,054	(357,173)	3,613,881			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,712,655	1,023,000	3,586,999	12,322,654		12,322,654	(358,507)	11,964,147			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 (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,775	1,775		1,775	104,451	106,226			30
31	Amortization of Pre-Op. & Org.							1,690	1,690			31
32	Interest							228,007	228,007			32
33	Real Estate Taxes			603,174	603,174		603,174		603,174			33
34	Rent-Facility & Grounds			936,000	936,000		936,000	(936,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			100,000	100,000		100,000	(100,000)				36
37	TOTAL Ownership			1,640,949	1,640,949		1,640,949	(701,852)	939,097			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,165		63,165		63,165		63,165			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,002,757	1,002,757		1,002,757		1,002,757			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		63,165	1,002,757	1,065,922		1,065,922		1,065,922			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,712,655	1,086,165	6,230,705	15,029,525		15,029,525	(1,060,359)	13,969,166			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(34,593)	30		9
10	Interest and Other Investment Income	(2,734)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,334)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(18,485)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,250)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(300,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,000)	36		24
25	Fund Raising, Advertising and Promotional	(18,914)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,524)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (495,834)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	(564,525)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (564,525)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,060,359)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			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	0		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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

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	100.00%	\$	\$ (60,000)	1
2	V								2
3	V	34	Rent	876,000	Birchwood Plaza			(876,000)	3
4	V	32	Interest		Birchwood Plaza		230,741	230,741	4
5	V	30	Depreciation		Birchwood Plaza		139,044	139,044	5
6	V	31	Amortization		Birchwood Plaza		1,690	1,690	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			\$ 371,475	\$ * (564,525)	14

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Dobson Nursing Plaza & Rehab LLC	Evanston, Ill			Birchwood Assoc	Chicago	Bldg Rental	1
2					CDC LLC	Chicago	Parking Lot Rental	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

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	Cynthia Kohn		Bookkeeper		51,504	20	50.00	Salary	\$ 57,000	22-1	1
2	Rebecca Kohn		Cons		63,240	20	50.00	Salary	53,400	22-1	2
3	Arthur Kohn		Adm	75.00		40	100.00	Mgmt Fee	593,664	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 704,064		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: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Birchwood Plaza # 0028696 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	CIBC Bank		X	Mortgage		3/14/17	\$ 9,000,000	\$ 2,987,869			\$ 230,741	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 9,000,000	\$ 2,987,869			\$ 230,741	9	
	B. Non-Facility Related*												
10	Interest Income		X								(2,734)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (2,734)	14	
15	TOTALS (line 9+line14)						\$ 9,000,000	\$ 2,987,869			\$ 228,007	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.)

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

FACILITY NAME	Birchwood Plaza	COUNTY	Cook
---------------	-----------------	--------	------

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

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).

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases?
H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement?
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. 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: 44,974 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 1,690 4. Dates Incurred: 4/7/22

Nature of Costs: Legal 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	Nursing Home		1984	\$ 80,569	1
2	Parking Lot		1987	30,081	2
3	TOTALS			\$ 110,650	3

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	192		1984		\$ 2,238,672	\$	40	\$	\$	2,248,698
5										
6										
7										
8										
	Improvement Type**									
9	Concrete Paving & Rails		1984		13,495		20			13,495
10	Sprinkler Modification		1984		2,752		25			2,752
11	Lobby Renovation		1984		2,489		40			2,489
12	Terrace Resurface		1984		7,600		15			7,600
13	Foyer Re-Flooring		1985		1,835		20			1,835
14	Basement Renovation		1985		18,061		40			18,061
15	Nursing Station Remodeling Per Audit 7755		1985				20			
16	Asphalt Roof		1985		7,000		15			7,000
17	Nurse Call System Rewire		1985		4,066		15			4,066
18	Sprinkler Modification		1985		2,963		25			2,963
19	Basement Awnings		1985		1,620		15			1,620
20	Gravel Roof		1985		2,700		5			2,700
21	Ceiling Basement Nursing Office		1985		1,200		20			1,200
22	Elevator Overhaul Per Audit 12800		1985							
23	Various (Electric & Sprinkler)		1986		5,486		20			5,486
24	Electrical Panel		1988		6,000		20			6,000
25	Electrical Improvements		1990		1,200		20			1,200
26	Elevator Improvements		1990		15,600		20			15,600
27	Tuckpointing & Brickwork		1990		12,300		20			12,300
28	Laundry Room Ductwork		1990		3,000		20			3,000
29	Bldg Extension For Office/Act Room/Dr		1994		282,054		20			282,054
30	Drapery		1994		7,933		5			7,933
31	Roof & Parking Lot Improvements Per Audit 36500		1995		33,484		15			33,484
32	Enlarge Patient Rooms(Trans to CI-C 97 Audit)		1997							
33	Windows		1998		41,775		25			41,775
34	Siding		1998		20,000		25			20,000
35	Patient Room Exhaust System		1998		9,720		20			9,720
36	Elevator Safety Device		1998		5,350		15			5,350

*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:

01/01/2025

Ending:

12/31/2025

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Bldg Extension(1994)Allowed for 1998	1998	\$ 49,866	\$	20	\$	\$	\$ 49,866	37
38	Rooftop A/C	1999	58,870		39	1,509	1,509	39,988	38
39	Lighting/Hand Rails/Flooring/Drapes	1999	27,264		39	699	699	18,524	39
40	Carpeting/Draperies	2000	5,062		7			5,062	40
41	A/C System	2000	6,395		27.5	233	233	5,970	41
42	Water Lines,Venting& Heating,Iron Railing	2001	5,165		27.5	188	188	4,629	42
43	Elev Upgrade/Front Outdoor Wall Syst Per Audit	2001	88,201		27.5	3,244	3,244	79,884	43
44	Carpeting/Draperies	2001	8,264		7			8,264	44
45	Draperies Per Audit 7753	2001							45
46	Wallpaper/ Carpeting Per Audit 18309	2002							46
47	Nurses Station	2002	15,101		27.5	549	549	12,741	47
48	Wallpaper/Elevator Upgrade Per Audit 13835	2003			27.5	503	503	10,950	48
49	Wallpaper/Carpentry	2004	46,774		27.5	1,701	1,701	36,000	49
50	Wallpaper/Carpentry/Remodeling	2005	18,014		27.5	655	655	13,416	50
51	Circulating Pump	2005	4,139		27.5	150	150	3,064	51
52	Phone Syst/Wallpaper/Floor/Carpentry/Remod	2006	13,703		27.5	498	498	9,919	52
53	Fire Supression Syst/Light Fixtures	2006	5,719		27.5	208	208	4,082	53
54	Elev Door Restrictor/Pump/Sensors	2006	6,784		27.5	247	247	4,827	54
55	Grease Trap/Plumbing/Concrete/Thru Wall A/C	2006	12,014		27.5	437	437	8,503	55
56	Nurses Station/Kitchen Tile	2006	14,907		27.5	542	542	10,423	56
57	Nursing Station/Flooring/Lighting/Thru Wall A/C	2007	11,968		27.5	435	435	8,186	57
58	Flooring/Carpeting/Wallpaper	2007	20,700		7			20,700	58
59	Accoustical Wall Tile/Floor Tile	2007	5,315		27.5	193	193	3,549	59
60	LL Office/Bathrooms/Tile/Locks/Wiring/Thr Wall A/C	2008	45,488		27.5	1,654	1,654	28,832	60
61	Carpeting Per Audit 2030	2008							61
62	Roof	2009	68,700		27.5	2,498	2,498	40,697	62
63	Security Sys/Wiring/Cable/Outlets Per Audit 7500	2009	49,737		27.5	2,082	2,082	33,735	63
64	Tile/Dry Wall/Toilets/Sinks/Light Fixtures/Painting								64
65		2009	24,135		27.5	877	877	14,187	65
66	Carpentry/built Ins/Molding/Tile/Electric/Ceiling	2009	14,653		27.5	533	533	8,552	66
67	Painting/Wallcovering/Carpeting	2009	70,916		7			70,916	67
68	Mirrors/Ceiling/Light Fixtures/Rails/Bumpers	2010	13,883		27.5	505	505	8,059	68
69	Elevator Motor/Starter	2010	5,680		27.5	207	207	3,303	69
70	TOTAL (lines 4 thru 69)		\$ 3,465,772	\$		\$ 20,347	\$ 20,347	\$ 3,325,209	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:

01/01/2025 Ending: 12/31/2025

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	
	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	\$		\$ 20,347	\$ 20,347	\$ 3,325,209	1
2	Fire Code-Dampers/Ducts/Sprinklers/Wall Ext	2010	45,802		27.5	1,665	1,665	26,016	2
3	Bathroom Tub/Tiles/Fixtures/Painting	2010	18,773		27.5	683	683	10,615	3
4	Built In Wardrobes/Cabinets/Doors/Countertop	2010	37,056		27.5	1,347	1,347	20,935	4
5	Trees/Shrubs/Perennials/Hardscape/Epoxy Stone	2010	24,949		15	1,664	1,664	25,790	5
6	Sump Pump & Control Panel	2010	12,061		27.5	439	439	6,823	6
7	Wallpaper/Painting/Carpeting/Draperies/Curtains	2010	84,560		7			84,560	7
8	Light Fixtures/Circuit Panel	2010	3,682		27.5	134	134	2,071	8
9	30 HP Compressor	2010	15,835		27.5	575	575	8,896	9
10	Painting/Carpeting/Tile/Cove Base/Draperies	2010	22,385		7			22,385	10
11	Outside Brickwork & Window Trim/Caulk/Tuckpointing	2011	11,000		27.5	400	400	5,683	11
12	Fire Dampers	2011	13,620		27.5	495	495	6,992	12
13	Closet Project-Carpentry/Doors/Access Panel	2011	11,094		27.5	403	403	5,692	13
14	Painting/2nd Floor Dining Room Carpentry/Chair Rails								14
15		2011	22,202		7			22,202	15
16	3 Boilers Heating & 2 Boilers Water	2011	126,330		27.5	4,593	4,593	64,112	16
17	Boiler Rm/3rd Floor Closet Project/2nd Floor Living Room								17
18	Flooring/Tiles/Cove Base/Window Treatment	2012	24,987		27.5	909	909	12,234	18
19	East Elevator Jack/Cylinder/Valves/Guide Shoe	2012	40,708		27.5	1,480	1,480	19,795	19
20	Compressor Parts/Piping/Fire Dampers	2012	9,490		27.5	345	345	4,373	20
21	Intercom Call System-Wiring	2013	6,547		27.5	238	238	3,016	21
22	Demolition & Reconstruction 1st & 2nd Floor	2013	7,103		27.5	258	258	3,255	22
23	Drill Tap & 6 Pump Valves for Compressor System	2013	8,820		27.5	321	321	3,974	23
24	Kitchen Dishwashing Areas-Flooring/Tile/Cove base								24
25	Carpentry/Trim/Stain Per audit 2189	2013	20,092		27.5	810	810	9,935	25
26	Exterior Brickwork/Tuckpointing/Blacktop	2013	12,722		27.5	463	463	5,651	26
27	Install Infared Elevator Beamed Safety System	2014	3,950		27.5	144	144	1,674	27
28	Built-In Kitchen Stove Hood	2014	4,000		27.5	145	145	1,650	28
29	Level 2nd Floor Ding Room,Cement Floor	2015	2,767		27.5	101	101	1,031	29
30	Install Concrete Pad behind Bldg for Generator	2015	8,000		27.5	291	291	2,946	30
31	Install 4" Gas Line & Valves for New Generator	2015	8,325		27.5	303	303	36,385	31
32	85KW Gas Generator,Design Fee,2" Gas Line,Fence Surround	2016	112,884		27.5	4,104	4,104	16,300	32
33	Replace Cylinder on West Passenger Elevator	2016	38,900		27.5	1,414	1,414	13,610	33
34	TOTAL (lines 1 thru 33)		\$ 4,224,416	\$		\$ 44,071	\$ 44,071	\$ 3,773,810	34

**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:

01/01/2025

Ending:

12/31/2025

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,224,416	\$		\$ 44,071	\$ 44,071	\$ 3,773,810	1
2	New Flat Roof Protective Coating	2016	49,974		27.5	1,817	1,817	11,543	2
3	Replace Vinyl Tile & Cove Base in Resident Rooms 104/106/127	2016	9,952		27.5	362	362	3,394	3
4	Install 12 Outlets & 2 Fuse Boxes	2016	21,000		27.5	764	764	6,972	4
5	Replace West Elevator Valve	2016	6,250		27.5	227	227	2,053	5
6	Electrical Wiring for Upgrades to Fire Alarm System Connections								6
7	to Both Elevators & generators	2017	9,775		27.5	355	355	3,003	7
8	Carpeing	2018	13,853		7	1,484	1,484	11,872	8
9	New Pump Unit for East Elevator	2018	7,500		27.5	272	272	2,006	9
10	16 Electrical & Lighting Units	2018	5,200		27.5	189	189	1,362	10
11	19 Improvements Hanna Z Interiors/New Flooring & Draperies	2019	7,934		27.5	289	289	2,044	11
12	Install Top Layer of Concrete on Second Floor Outer Dining Room	2019	3,800		27.5	138	138	828	12
13	Installed 27 Windows in Resident Rooms	2019	3,915		27.5	142	142	852	13
14	Elevator Repairs/Chicago El Co/Replaced Detectors	2019	2,950		27.5	107	107	642	14
15	Roof Repairs on Flat Roof	2020	8,200		27.5	298	298	1,788	15
16	Replace Compressor of A/C in Utility Room	2021	14,900		15	993	993	4,965	16
17									17
18									18
19	Capital Cost Report Audit Adjustment		109,686						19
20									20
21	2 Sump Pumps	2022	15,085		15	1,006	1,006	4,024	21
22	New Backflow	2022	10,365		15	691	691	2,764	22
23	Patio Carpeting	2022	7,372		15	491	491	1,964	23
24	Removed Old Compressor due to Leaking, Installed New Compres	2024	13,585		15	906	906	1,812	24
25	New Hallway Carpeting	2024	3,600		15	240	240	480	25
26	Passenger Elevator Door Repair	2024	6,257		15	417	417	834	26
27	Replaced Dryer Motor	2024	2,602		15	173	173	346	27
28	Removed Old Floor Tiles and Replaced With New Tiles	2024	39,966		15	2,665	2,665	5,330	28
29	Electrical & Lighting Pipe with #2 Wires to Second Floor To								29
30	Feed The Panel	2025	9,200		15	613	613	613	30
31	Replace Rooftop Cooling Tower with New Fiberglass Tower	2025	31,425		15	2,095	2,095	2,095	31
32									32
33	Financial Statement Depreciation			108,365			(108,365)		33
34	TOTAL (lines 1 thru 33)		\$ 4,638,762	\$ 108,365		\$ 60,805	\$ (47,560)	\$ 3,847,396	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	\$ 423,533	\$ 1,775	\$ 42,353	\$ 40,578	10	\$ 377,294	71
72	Current Year Purchases	30,679	30,679	3,068	(27,611)	10	3,068	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 454,212	\$ 32,454	\$ 45,421	\$ 12,967		\$ 380,362	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	Administrative	Lexus	2009	\$ 44,566	\$	\$	\$		\$ 44,566	76
77										77
78										78
79	Van		1998	13,600					13,600	79
80	TOTALS			\$ 58,166	\$	\$	\$		\$ 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)	\$ 5,261,790	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 140,819	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 106,226	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (34,593)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,285,924	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
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$
- Description:
-
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
- Beginning
- Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.

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	

- (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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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 prescrpts				63,165		63,165	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 63,165		\$ 63,165	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,558,105	\$ 5,966,847	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,920,509	1,920,509	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	283,460	283,460	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Related</u>	1,019,633	1,829,633	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,781,707	\$ 10,000,449	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		2,371,123	15
16	Equipment, at Historical Cost	44,566	504,333	16
17	Accumulated Depreciation (book methods)	(43,461)	(4,474,966)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		53,425	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(50,889)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>501K Ins Contract</u>	148,682	148,682	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 149,787	\$ 864,874	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,931,494	\$ 10,865,323	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 635,661	\$ 635,661	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	382,125	382,125	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	383,372	383,372	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,838	34,838	31
32	Accrued Real Estate Taxes(Sch.IX-B)	590,377	590,377	32
33	Accrued Interest Payable		18,579	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Others</u>	976,953		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,003,326	\$ 2,044,952	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,987,869	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,987,869	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,003,326	\$ 5,032,821	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,928,168	\$ 5,832,502	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,931,494	\$ 10,865,323	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,697,677	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,697,677	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,030,491	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	(800,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 230,491	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)	\$ 2,928,168	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Birchwood Plaza

0028696

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 16,057,282	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,057,282	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,734	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,734	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)	\$ 16,060,016	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,084,417	31
32	Health Care	6,267,183	32
33	General Administration	3,971,054	33
	B. Capital Expense		
34	Ownership	1,640,949	34
	C. Ancillary Expense		
35	Special Cost Centers	63,165	35
36	Provider Participation Fee	1,002,757	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,029,525	40
41	Income before Income Taxes (line 30 minus line 40)**	1,030,491	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,030,491	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 3,104,858.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,666,912.00	45
46	MMAI-Medicaid is the Primary Payer	19,074.00	46
47	MMAI-Medicare is the Primary Payer	141,529.00	47
48	Private Pay	2,682,299.00	48
49	Medicare Part A	2,142,013.00	49
50	Other-(specify) Medicare-B	300,597.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 16,057,282	56

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	2,125	2,505	\$ 133,497	\$ 53.29	1
2	Assistant Director of Nursing	2,480	2,870	173,637	60.50	2
3	Registered Nurses	32,345	35,211	1,562,329	44.37	3
4	Licensed Practical Nurses	10,980	11,886	457,115	38.46	4
5	CNAs & Orderlies	105,483	113,658	2,580,004	22.70	5
6	CNA Trainees					6
7	Licensed Therapist	7,060	7,381	368,265	49.89	7
8	Rehab/Therapy Aides	2,975	3,178	160,980	50.65	8
9	Activity Director	832	896	30,152	33.65	9
10	Activity Assistants	6,966	6,948	160,861	23.15	10
11	Social Service Workers	4,819	4,995	238,908	47.83	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,216	76,031	34.31	13
14	Head Cook	1,823	2,095	48,516	23.16	14
15	Cook Helpers/Assistants	13,436	14,447	281,256	19.47	15
16	Dishwashers					16
17	Maintenance Workers	3,481	3,992	160,400	40.18	17
18	Housekeepers	16,716	18,266	372,980	20.42	18
19	Laundry	6,036	6,769	151,507	22.38	19
20	Administrator	2,080	2,080	205,413	98.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,288	16,943	550,804	32.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	237,917	256,336	\$ 7,712,655 *	\$ 30.09	34

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	Monthly	\$ 5,472	1-3	35
36	Medical Director	Monthly	6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,615	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,087		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	476	\$ 28,580	10-3	50
51	Licensed Practical Nurses	1,200	54,114	10-3	51
52	Certified Nurse Assistants/Aides	142	4,228	10-3	52
53	TOTAL (lines 50 - 52)	1,818	\$ 86,922		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Abraham Schiffman	Administrator	0	\$ 205,413	Workers' Compensation Insurance	\$	67,112	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		39,113	Advertising: Employee Recruitment	207	
				FICA Taxes		561,850	Health Care Worker Background Check	2,034	
				Employee Health Insurance		697,575	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks	280	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
							CHUG	1,140	
							Various	2,812	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 205,413				Less: Public Relations Expense	()	
B. Administrative - Other							PAC and Lobbying payments	()	
Description			Amount				All non-allowable advertising	()	
Arthur Kohn-Mgmt Fee			\$ 593,664				TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 8,463		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 593,664	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,365,650		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Mendel Schneider CPA	Accounting		\$ 21,000			\$	Out-of-State Travel	\$	
Roth & Co	Accounting		16,000						
Neil Schaum	Accounting		20,450						
McCabe Kirshner	Legal		5,688				In-State Travel		
Schueler Dallado & Casieri	Legal		407						
DDV Law	Legal		1,379						
Much Shelist	Legal		3,203						
JAMMA Cons	MDS Cons		65,550				Seminar Expense		
Medicaid Support	Medicaid Cons		4,000						
2401 Inc	Architech		2,770						
CNA Ins	Adjusted Out		300,000						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 440,447	TOTAL			\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 77,516 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 1,002,757

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ Has any meal income been offset against related costs? Indicate the amount. \$
- (12)

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?

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?

d. Have vehicle usage logs been maintained?

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training?

Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: No
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

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.

Attach invoices and a summary of services for all architect and appraisal fees.