

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0051508 Facility Name: DOBSON PLAZA Address: 120 DODGE AVENUE EVANSTON 60202 County: COOK Telephone Number: (847) 869-7744 Fax # (847) 570-0112 HFS ID Number: Date of Initial License for Current Owners: 05/01/2011 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: SANFORD BOKOR Telephone Number: (847) 675-3585 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 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. Officer or Administrator of Provider (Signed) (Type or Print Name) CHARLOTTE KOHN (Title) ADMINISTRATOR Paid Preparer (Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Print Name and Title) SANFORD BOKOR PRESIDENT (Firm Name & Address) KBKB, LTD 8140 RIVER DRIVE, MORTON GROVE, IL 60053 (Telephone) (847) 675-3585 Fax # (847) 675-5777 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number DOBSON PLAZA

0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	<u>97</u>	Skilled (SNF)	<u>97</u>	<u>35,502</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,502</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,808</u>	<u>2,808</u>	8
9	SNF/PED					9
10	ICF	<u>19,715</u>	<u>9,299</u>	<u>732</u>	<u>29,746</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,715</u>	<u>9,299</u>	<u>3,540</u>	<u>32,554</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.70%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 07/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/01/2011 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 97 and days of care provided 2,808

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **DOBSON PLAZA** # **0051508** Report Period Beginning: **01/01/2016** Ending: **12/31/2016**

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	161,688	9,111	16,760	187,559		187,559	0	187,559			1
2	Food Purchase		160,126		160,126	(11,096)	149,030	(684)	148,346			2
3	Housekeeping	59,232	40,801	0	100,033		100,033	0	100,033			3
4	Laundry	25,161	12,101	5,432	42,694	0	42,694	0	42,694			4
5	Heat and Other Utilities			82,792	82,792		82,792	0	82,792			5
6	Maintenance	49,990	9,659	44,170	103,819		103,819	0	103,819			6
7	Other (specify):*			7,953	7,953		7,953	0	7,953			7
8	TOTAL General Services	296,071	231,798	157,107	684,976	(11,096)	673,880	(684)	673,196			8
	B. Health Care and Programs											
9	Medical Director	0		12,000	12,000		12,000	0	12,000			9
10	Nursing and Medical Records	2,065,562	102,557	8,686	2,176,805		2,176,805	0	2,176,805			10
10a	Therapy	0	5,102	144,053	149,155		149,155	0	149,155			10a
11	Activities	89,731	20,565	0	110,296		110,296	0	110,296			11
12	Social Services	28,627		3,840	32,467		32,467	0	32,467			12
13	CNA Training			0	0		0	0	0			13
14	Program Transportation			305	305		305	0	305			14
15	Other (specify):*			0	0		0	0	0			15
16	TOTAL Health Care and Programs	2,183,920	128,224	168,884	2,481,028	0	2,481,028	0	2,481,028			16
	C. General Administration											
17	Administrative	273,309		218,646	491,955		491,955	(294,635)	197,320			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			74,922	74,922		74,922	1,500	76,422			19
20	Dues, Fees, Subscriptions & Promotions			54,939	54,939		54,939	(41,226)	13,713			20
21	Clerical & General Office Expenses	102,339	15,560	28,206	146,105		146,105	(5,886)	140,219			21
22	Employee Benefits & Payroll Taxes			469,861	469,861	11,096	480,957	0	480,957			22
23	Inservice Training & Education			1,146	1,146		1,146	0	1,146			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			4,414	4,414		4,414	0	4,414			25
26	Insurance-Prop.Liab.Malpractice			81,390	81,390		81,390	0	81,390			26
27	Other (specify):*			0	0		0	0	0			27
28	TOTAL General Administration	375,648	15,560	933,524	1,324,732	11,096	1,335,828	(340,247)	995,581			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,855,639	375,582	1,259,515	4,490,736	0	4,490,736	(340,931)	4,149,805			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	16,760
	REPAIRS & MAINTENANCE		0
			16,760
3	HOUSEKEEPING		
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		5,432
			5,432
5	HEAT & OTHER UTILITIES		
	GAS HEAT		13,642
	ELECTRICITY		35,145
	WATER		28,597
	CABLE TV - LOBBY		5,408
			82,792
6	MAINTENANCE		
	GROUNDS MAINTENANCE		2,036
	PAINTING & DECORATING		806
	BUILDING REPAIRS		2,345
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		12,547
	ELEVATOR MAINTENANCE & REPAIR		6,116
	OUTSIDE LABOR		1,322
	EXTERMINATING SERVICE		2,796
	FIRE SERVICE		16,202
			44,170
7	OTHER		
	SCAVENGER		7,953
	SECURITY SERVICE		0
			7,953
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	5,000
	PHARMACY CONSULTANT	XVIII B 39-2	3,686
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
			8,686
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		81,591
	SPEECH THERAPY SERVICES		924
	OCCUPATIONAL THERAPY SERVICES		60,833
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	705
			144,053
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
	CLERGY		0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	3,840
			3,840
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	305	
			305
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 218,646	218,646
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 25,970	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 48,952	
			74,922
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 1,912	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 23,512	
	EMPLOYEE WANT ADS	XIX F 0	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 0	
	LICENSES & PERMITS	XIX F 10,718	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 17,714	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 1,003	
	PATIENT BACKGROUND CHECKS	XIX F 80	
			54,939
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0	
	EQUIPMENT REPAIR & MAINTENANCE	4,788	
	OUTSIDE CLERICAL SERVICES	5,293	
	PENALTIES / OVERDRAFT CHARGES	VI 18 5,889	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	12,236	
	MESSENGER SERVICE	0	
			28,206

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 200,292	
	UNEMPLOYMENT COMPENSATION	XIX D 8,033	
	WORKERS COMPENSATION INSURANC	XIX D 41,003	
	HOSPITALIZATION INSURANCE	XIX D 195,947	
	EMPLOYEE BENEFITS - OTHER	XIX D 28,675	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	501 PLAN - CASH VALUE ADJ	XIX D (4,089)	
			469,861
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	1,146	
			1,146
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	4,414	
			4,414
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	81,390	
			81,390
27	OTHER		
	BAD DEBTS	VI 24 0	
			0

GRAND TOTAL COLUMN 3 OTHER

1,259,515

DOBSON PLAZA
SCHEDULES
12/31/2016

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	160,126
LESS SALES TAX	<u>(684)</u>
NET FOOD	159,442
TOTAL PATIENT CENSUS	32,554
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	97,662
ADD # EMPLOYEE MEALS/DAY	20
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	7,300
PATIENT MEALS	97,662
ADD EMPLOYEE MEALS	<u>7,300</u>
TOTAL MEALS/YEAR	104,962
NET FOOD	159,442
DIVIDE TOTAL MEALS/YEAR	<u>104,962</u>
COST PER MEAL	1.52
TIMES EMPLOYEE MEALS	<u>7,300</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>11,096</u></u>

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			11,560	11,560		11,560	60,526	72,086			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			1,045	1,045		1,045	103,264	104,309			32
33	Real Estate Taxes			231,521	231,521		231,521	0	231,521			33
34	Rent-Facility & Grounds			1,020,000	1,020,000		1,020,000	(1,020,000)	0			34
35	Rent-Equipment & Vehicles			0	0		0	0	0			35
36	Other (specify):* STORAGE			4,470	4,470		4,470	0	4,470			36
37	TOTAL Ownership			1,268,596	1,268,596	0	1,268,596	(856,210)	412,386			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		108,570	287,684	396,254		396,254	0	396,254			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			231,888	231,888		231,888	0	231,888			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	108,570	519,572	628,142	0	628,142	0	628,142			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,855,639	484,152	3,047,683	6,387,474	0	6,387,474	(1,197,141)	5,190,333			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	(6,114)	30		9
10	Interest and Other Investment Income	(296)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary	(218,646)	17		12
13	Sales Tax	(684)	2		13
14	Non-Care Related Interest	(200)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,889)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,512)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(17,714)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(75,989)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (349,044)		\$ 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 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)	(848,097)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (848,097)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,197,141)		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.		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DISALLOWED EXCESS OWNER SALARY	\$ (75,989)	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	(75,989)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA# 0051508

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(684)	0	0	0	0	0	0	0	0	0	0	(684)	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	(684)	0	0	0	0	0	0	0	0	0	0	(684)	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	(294,635)	0	0	0	0	0	0	0	0	0	0	(294,635)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,500	0	0	0	0	0	0	0	0	0	1,500	19
20	Fees, Subscriptions & Promotions	(41,226)	0	0	0	0	0	0	0	0	0	0	(41,226)	20
21	Clerical & General Office Expenses	(5,889)	3	0	0	0	0	0	0	0	0	0	(5,886)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(341,750)	1,503	0	0	0	0	0	0	0	0	0	(340,247)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(342,434)	1,503	0	0	0	0	0	0	0	0	0	(340,931)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(6,114)	66,640	0	0	0	0	0	0	0	0	0	60,526	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(496)	103,760	0	0	0	0	0	0	0	0	0	103,264	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,020,000)	0	0	0	0	0	0	0	0	0	(1,020,000)	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	(6,610)	(849,600)	0	0	0	0	0	0	0	0	0	(856,210)	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)	(349,044)	(848,097)	0	0	0	0	0	0	0	0	0	(1,197,141)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
CHARLOTTE KOHN	99%	BIRCHWOOD PLAZA INC	CHICAGO, IL	DOBSON PLAZA INC		REAL ESTATE
ARTHUR J KOHN	1%				EVANSTON	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	\$ 1,020,000	DOBSON PLAZA INC		\$	(1,020,000)	1
2	V	30	SL DEPRECIATION		" "		66,640	66,640	2
3	V	32	INTEREST		" "		103,760	103,760	3
4	V	21	OFFICE EXPENSE		" "		3	3	4
5	V	19	ACCOUNTING FEES		" "		1,500	1,500	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			\$ 1,020,000			\$ 171,903	\$ * (848,097)	14

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	ADMINISTRATOR	SUPERVISION	99.00	90,000	33	55.00	SALARY	\$ 110,000	17-1	1
2	BARAK KOHN	BUILDING ADMIN	SUPERVISION	0.00	11,181	18	60.00	SALARY	28,654	17-1	2
3	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	52,666	6	50.00	SALARY	58,666	17-1	3
4											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	\$ 197,320		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 DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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	MB FINANCIAL		X	AUTO LOAN	\$1,188.14	08/16/16	\$ 66,057	\$ 62,007	08/16/21	PRIME+	\$ 845	1	
2												2	
3												3	
4	RELATED PARTY - DOBSON PLAZA INC:											4	
5	MB FINANCIAL		X	MORTGAGE	\$32,880.35	12/16/04	5,500,000	2,748,943	12/05/19	0.0325	103,760	5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$34,068.49		\$ 5,566,057	\$ 2,810,950			\$ 104,605	9	
	B. Non-Facility Related*												
10	LATE FEES										200	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 200	14	
15	TOTALS (line 9+line14)						\$ 5,566,057	\$ 2,810,950			\$ 104,805	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

* 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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOBSON PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051508

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 10-25-113-043-0000	NURSING HOME	\$ 659.46	\$ 659.46
2. 10-25-220-015-0000	NURSING HOME	\$ 230,551.40	\$ 230,551.40
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 231,210.86	\$ 231,210.86

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

22,536

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

3

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	RELATED PARTY - DOBSON PLAZA INC:			\$	1
2	NURSING HOME	18,167	1966	80,509	2
3	TOTALS	18,167		\$ 80,509	3

Facility Name & ID Number DOBSON PLAZA

0051508

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		RELATED PARTY-DOBSON PLAZA INC:			\$	\$		\$	\$	\$	4
5	58		1966	1966	251,171		35			251,171	5
6	33			1987	930,705	38,099	40	23,268	(14,831)	683,965	6
7	2			1971	11,147		8-12			11,147	7
8	4	per audit -64011		1987	0		30				8
	Improvement Type**										
9		ELECTRICAL & PLUMBING		1976	1,027		8			1,027	9
10		SPRINKLER SYSTEM		1982	9,921		15			9,921	10
11		NURSING OFFICE		1982	891		15			891	11
12		RENOVATE NURSING STATION per audit -5,223		1986	0		20				12
13		LANDSCAPING		1988	6,905		10			6,905	13
14		LAND IMPROVEMENTS - SEWER		1988	5,650		25			5,650	14
15		LAND IMPROVEMENTS - FENCING		1988	1,878		15			1,878	15
16		LAND IMPROVEMENTS - PAVING per audit -12,335		1988	0		20				16
17		OUTSIDE SIGN		1988	2,473		12			2,473	17
18		SPRINKLER SYSTEM		1988	42,241		25			42,241	18
19		HEATING, VENTILATION, & A/C		1988	48,620		20			48,620	19
20		PLUMBING COMPOSITE		1988	63,062		25			63,062	20
21		ELECTRICAL WIRING		1988	115,484		20			115,484	21
22		BRICK-ENCLOSED GENERATOR		1989	1,375		25			1,375	22
23		FENCE - GENERATOR		1989	480		15			480	23
24		CATCH BASIN		1989	5,000		10			5,000	24
25		REMODELLING OF ANCILLARY AREAS per audit -18,867		1997	516,118	16,180	40	13,374	(2,806)	267,480	25
26		CANOPY SIGN		1999	8,000	205	39	205		3,562	26
27		ELEVATOR REPAIR per audit -1,990		1999	0	51	39		(51)		27
28		FIRE DAMPERS / AIR INTAKES		2000	10,515	382	27.5	382		6,351	28
29		ELEVATOR UPGRADE / AIR INTAKES per audit -10,038		2000	18,221	1,028	27.5	1,028		16,577	29
30		ELEVATOR UPGRADE per audit -756		2001	18,221	690	27.5	690		10,896	30
31		CARPETING per audit -1,683		2001	23,914		10			23,914	31
32		HEAT EXCHANGER 8,650/ FIRE SUPPRESSION SYSTEM 2,922		2003	11,572	421	27.5	421		5,780	32
33		HYDRAULIC ELEVATOR PUMP		2006	10,772	392	27.5	392		4,230	33
34		BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER		2006	29,463	1,071	27.5	1,071		11,352	34
35		NURSG STN/BATHRMS/PLUMBG/FLOORING/ROOF FASCIA		2007	53,627	1,950	27.5	1,950		18,605	35
36		BEAUTY SHOP DRYWALL,CABINETRY,PLUMBING,TILE		2007	7,287	265	27.5	265		2,374	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number DOBSON PLAZA

0051508

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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	METAL EXIT DOORS / FIRE RETARDANT CEMENT	2008	\$ 8,404	\$ 306	27.5	\$ 306	\$	\$ 2,719	37
38	PT,AAD,DAYRMS-DRYWALL,FLOORING,STUDS,JOIST	2008	19,380	705	27.5	705		6,198	38
39	BATHRMS:TILE,FLOOR,DRYWALL,PAINT,PAPER,FIXTURI	2008	15,425	561	27.5	561		4,846	39
40	REPIPE KITCHEN WATER LINES	2008	2,065	75	27.5	75		655	40
41	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	109	27.5	109		933	41
42	LOWER LEVEL BATHROOM PROJECT	2008	26,300	956	27.5	956		7,783	42
43	LOWER LEVEL NURSING STATION	2008	12,500	455	27.5	455		3,697	43
44	UPPER ROOF REPLACEMENT	2008	18,500	673	27.5	673		5,468	44
45	CARPETING	2008	11,259		10	1,126	1,126	10,137	45
46	DRIVEWAY/PARKINGLOT	2008	18,807	1,254	15	1,254		10,658	46
47	THERAPY ROOM WALL/SHELVING/CARPENTRY/6 DOORS	2009	5,530	201	27.5	201		1,591	47
48	2ND FLOOR ROOF/5-TON AC CONDENSER per audit -1,300	2009	11,025	443	27.5	443		3,437	48
49	SECURITY SYSTEM/CABLES/WANDERGUARD WIRING	2009	5,671	206	27.5	206		1,578	49
50	CARPENTRY/RECESSED LIGHTING/WIRING 28 OUTLETS	2009	7,975	290	27.5	290		2,115	50
51	SUMP PUMP MOTOR & PIPELINES	2009	3,700	135	27.5	135		986	51
52	CERAMIC FLOOR/CARPENTRY/CLOSET/INTERCOM/CABI	2009	2,919	107	27.5	108	1	761	52
53	CARPETING/WINDOW TREATMENTS/ per audit - 5,896	2009	7,403		10			7,403	53
54	OUTLETS/CABLE/WALL MOUNTS	2010	8,730	317	27.5	317		2,153	54
55	NURSING STATION BUILT-INS/DRYWALL per audit -900	2010	5,011	215	27.5	215		1,263	55
56	DELAYED ELEVATOR EGRESS LOCKS	2010	3,868	141	27.5	141		934	56
57	WALLPAPER/CARPETING/COVE BASE/BASEBOARDS	2010	12,741	368	10	1,274	906	8,281	57
58	SUMP PUMP	2010	7,719	281	27.5	281		1,745	58
59	WEIL PUMP 2224	2011	5,119	0	10	512	512	2,816	59
60	2ND FL NURSING STATION / CARPENTRY / BUILT-INS / CLOSET / RAILS / VINYL FLOORING:								60
61	per audit -2,632	2011	3,015	205	27.5	205		1,170	61
62	1ST FL NURSING STATION SOCKETS/LIGHTING/BUILT-IN KITCHEN CABINETS/BATHROOM TILEWORK,PIPING,DRYWALL/LIBRARY DU								62
63	& SEAL WINDOWS/1ST FL BATHROOM DEMOLITION-NEW DRYWALL/SOFFITS/CONCRETE/PLUMBING/ELECTRIC/TILING/FIXTURES/P								63
64	ROOM FLOORING per audit - 2,231	2012	48,520	1,845	27.5	1,845		8,226	64
65	A/C FOR DINING ROOM	2012	3,120	113	27.5	113		504	65
66	WIRING	2014	5,597	204	27.5	204		535	66
67	SECURITY SYSTEM UPGRADES	2015	3,100	496	5	620	124	801	67
68	ELEVATOR-RETRACTABLE LADDER & WIRING	2015	4,026	146	27.5	146		189	68
69	2ND FL CORRIDOR & DAYROOM FLOORING	2015	18,961	689	27.5	689		716	69
70	TOTAL (lines 4 thru 69)		\$ 2,515,145	\$ 72,230		\$ 57,211	\$ (15,019)	\$ 1,722,709	70

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

Facility Name & ID Number DOBSON PLAZA

0051508

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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 12A, Carried Forward		\$ 2,515,145	\$ 72,230		\$ 57,211	\$ (15,019)	\$ 1,722,709	1
2	HOT WATER TANK, INSTALLATION per audit -553	2016	10,253	264	27.5	264		264	2
3	1ST FLOOR CORRIDOR GLUE-DOWN CARPETING	2016	3,694	95	27.5	95		95	3
4	ELEVATOR MAIN CONTROL VALVE	2016	6,500	128	27.5	128		128	4
5									5
6									6
7	ADJUST TO STRAIGHT LINE			(15,019)			15,019		7
8									8
9									9
10	ADJUST TO BALANCE SHEET								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	TOTAL (lines 1 thru 33)		\$ 2,535,592	\$ 57,698		\$ 57,698	\$ 0	\$ 1,723,196	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	\$ 70,604	\$ 8,184	\$ 8,184	\$ 0	8-10 YRS	\$ 45,343	71
72	Current Year Purchases	12,127	758	758	0	8 YRS	758	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 82,731	\$ 8,942	\$ 8,942	\$ 0		\$ 46,101	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	ADMIN, BANKING,	'17 ACURA MDX	2016	\$ 65,357	\$ 11,560	\$ 5,446	\$ (6,114)	5 YRS	\$ 5,446
77	ACTIVITIES,MAINT,						0		
78	& PURCHASING,ETC						0		
79							0		
80	TOTALS			\$ 65,357	\$ 11,560	\$ 5,446	\$ (6,114)		\$ 5,446

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$ 2,764,189	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 78,200	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 72,086	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ (6,114)	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 1,774,743	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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			

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.)

		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	39-3	hrs	\$		\$ 95,116	\$		\$ 95,116	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			53,379			53,379	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			139,189			139,189	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				96,816		96,816	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					11,754		11,754	13
14	TOTAL			\$		\$ 287,684	\$ 108,570		\$ 396,254	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.

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	\$ 130,711	\$ 428,393	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,030,188	2,030,188	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		498,351	5
6	Prepaid Insurance	54,468	54,468	6
7	Other Prepaid Expenses	3,010	4,140	7
8	Accounts Receivable (owners or related parties)		889,995	8
9	Other(specify): <u>DUE TO DOBSON PLAZA INC</u>	793,144	0	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,011,521	\$ 3,905,535	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		80,506	13
14	Buildings, at Historical Cost		2,082,284	14
15	Leasehold Improvements, at Historical Cost		613,175	15
16	Equipment, at Historical Cost	65,357	206,167	16
17	Accumulated Depreciation (book methods)	(11,560)	(2,055,612)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>NY LIFE INSUR.CONTRACTS</u>	308,844	308,844	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 362,641	\$ 1,235,364	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,374,162	\$ 5,140,899	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 221,623	\$ 219,629	26
27	Officer's Accounts Payable	218,646	218,646	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	92,966	92,966	29
30	Accrued Salaries Payable	125,166	125,166	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,235	1,235	31
32	Accrued Real Estate Taxes(Sch.IX-B)		231,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MORTGAGE PAYABLE-CURRENT</u>		300,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 659,636	\$ 1,189,242	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	60,961	2,509,904	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	1,106,471	1,106,471	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,167,432	\$ 3,616,375	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,827,068	\$ 4,805,617	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,547,094	\$ 335,282	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,374,162	\$ 5,140,899	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,200,519	1
2	Restatements (describe):		2
3			3
4	ROUNDING	3	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,200,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,140,471	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	(1,793,899)	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)	\$ (653,428)	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)	\$ 1,547,094	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number DOBSON PLAZA

0051508

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	\$ 7,235,357	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,235,357	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	311,696	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 311,696	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,479	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,479	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	296	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 296	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,549,828	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	684,976	31
32	Health Care	2,481,028	32
33	General Administration	1,324,732	33
	B. Capital Expense		
34	Ownership	1,268,596	34
	C. Ancillary Expense		
35	Special Cost Centers	396,254	35
36	Provider Participation Fee	231,888	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,387,474	40
41	Income before Income Taxes (line 30 minus line 40)**	1,162,354	41
42	Income Taxes	(21,883)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,140,471	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,317,924	44
45	Private Pay - Net Inpatient Revenue	2,102,394	45
46	Medicare - Net Inpatient Revenue	1,632,144	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	182,895	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,235,357	49

****TAX RETURN PREPARED ON CASH BASIS**

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

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

*** 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.

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	1,825	2,072	\$ 99,305	\$ 47.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,003	25,858	822,160	31.80	3
4	Licensed Practical Nurses	4,394	5,009	128,895	25.73	4
5	CNAs & Orderlies	55,302	61,088	793,712	12.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,639	2,878	51,824	18.01	9
10	Activity Assistants	3,006	3,043	37,907	12.46	10
11	Social Service Workers	1,162	1,287	28,627	22.24	11
12	Dietician					12
13	Food Service Supervisor	1,143	1,152	35,898	31.16	13
14	Head Cook	1,145	1,159	17,868	15.42	14
15	Cook Helpers/Assistants	10,155	11,015	107,922	9.80	15
16	Dishwashers					16
17	Maintenance Workers	3,483	4,144	49,990	12.06	17
18	Housekeepers	4,715	5,311	59,232	11.15	18
19	Laundry	2,262	2,586	25,161	9.73	19
20	Administrator	2,091	2,091	185,989	88.95	20
21	Assistant Administrator	1,005	1,005	28,654	28.51	21
22	Other Administrative	522	522	58,666	112.39	22
23	Office Manager					23
24	Clerical	4,567	4,896	102,339	20.90	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	1,852	2,134	73,314	34.36	31
32	Other Health Care(specify)					32
33	Other(specify) ADMIT/QA	4,338	4,338	148,176	34.16	33
34	TOTAL (lines 1 - 33)	128,609	141,588	\$ 2,855,639 *	\$ 20.17	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	\$ 16,760	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	5,000	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,686	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	705	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	3,840	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,991		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	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)		\$		53

Facility Name & ID Number		DOBSON PLAZA		STATE OF ILLINOIS		# 0051508		Report Period Beginning:		01/01/2016		Page 21		Ending: 12/31/2016			
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions									
Name		Function		Ownership %		Amount		Description		Amount		Description		Amount			
CHARLOTTE KOHN		ADMINISTRATOR		**		\$ 185,989		Workers' Compensation Insurance		\$ 41,003		IDPH License Fee		\$ 3,980			
BARAK KOHN		ASST ADMIN		**		28,654		Unemployment Compensation Insurance		8,033		Advertising: Employee Recruitment		0			
REBECCA KOHN		OTHER ADMIN		**		58,666		FICA Taxes		200,292		Health Care Worker Background Check		1,003			
								Employee Health Insurance		195,947		(Indicate # of checks performed 32)					
								Employee Meals		11,096		Patient Background Checks		80			
** BY ATTRIBUTION 100% KOHN FAMILY OWNED								Illinois Municipal Retirement Fund (IMRF)*				TRUST/FRANCHISE/CONTRIB/ETC		0			
								EMPLOYEE BENEFITS - OTHER		28,675		MARKETING/ADV/PROMO		43,138			
								EMPLOYEE PHYSICAL EXAMS		0		LICENSES/DUES/SUBSCRIPTIONS		8,650			
TOTAL (agree to Schedule V, line 17, col. 1)								PENSION/PROFIT SHARING PLANS (CVA)		(4,089)							
(List each licensed administrator separately.)						\$ 273,309		INSURANCE - EXECUTIVE LIFE		0		TRUST/FRANCHISE/CONTRIB/ETC		0			
B. Administrative - Other												Less: Public Relations Expense				(1,912)	
Description						Amount						Non-allowable advertising		(23,512)			
ARTHUR KOHN		MANAGEMENT FEES				\$ 200,000		INSURANCE - EXECUTIVE LIFE		VI 21 0		Yellow page advertising		(17,714)			
								TOTAL (agree to Schedule V,		\$ 480,957		TOTAL (agree to Sch. V,		\$ 13,713			
								line 22, col.8)				line 20, col. 8)					
TOTAL (agree to Schedule V, line 17, col. 3)						\$ 200,000		E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)																	
C. Professional Services																	
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount	
ALPHA DATA SERVICES		DATA PROCESSING				\$ 4,894						\$		Out-of-State Travel		\$	
MDI ACHIEVE		DATA PROCESSING				21,076											
MYRON TUSHBAI		ACCOUNTING				9,045											
KBKB LLC		ACCOUNTING				20,700								In-State Travel			
RICHARD PEELO		MEDICARE COST REPORT				3,250										0	
PERSONNEL PLANNING		UNEMPLOYMENT CONSULT				600											
ADVANTAGE BENEFITS		501A CONSULTANT				1,306											
LEGAL		SEE SCHEDULE				14,051								Seminar Expense			
																0	
TOTAL (agree to Schedule V, line 19, column 3)						\$ 74,922		TOTAL		\$				Entertainment Expense		()	
(For legal fee disclosure, see page 39 of instructions)														(agree to Sch. V,			
														TOTAL		\$	
														line 24, col. 8)			
* Attach copy of IMRF notifications																	
**See instructions.																	

DOBSON PLAZA
SCHEDULE-LEGAL
12/31/2016

DATE	FIRM	INVOICE #	PURPOSE	COST	TOTAL COST
3.16	RIEFF SCHRAMM KANTER GUTTMAN	23201	REAL ESTATE TAX ABATEMENT-FILING FEE	225.00	225.00
1.16	STONE POGRUND KOREY	63576	LEGAL GUARDIANSHIP	897.63	
2.16	STONE POGRUND KOREY	64761	LEGAL GUARDIANSHIP	719.91	
3.16	STONE POGRUND KOREY	65484	LEGAL GUARDIANSHIP	1,672.50	
4.16	STONE POGRUND KOREY	66239	LEGAL GUARDIANSHIP	662.00	
5.16	STONE POGRUND KOREY	68148	LEGAL GUARDIANSHIP	200.00	
6.16	STONE POGRUND KOREY	68987	LEGAL GUARDIANSHIP	211.00	
7.16	STONE POGRUND KOREY	70085	LEGAL GUARDIANSHIP	562.50	
8.16	STONE POGRUND KOREY	71515	LEGAL GUARDIANSHIP	1,457.86	
9.16	STONE POGRUND KOREY	72598	LEGAL GUARDIANSHIP	4,363.63	
10.16	STONE POGRUND KOREY	73610	LEGAL GUARDIANSHIP	475.00	
11.16	STONE POGRUND KOREY	74321	LEGAL GUARDIANSHIP	587.50	
12.16	STONE POGRUND KOREY	75110	LEGAL GUARDIANSHIP	2,016.45	13,825.98
				TOTAL	14,050.98

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0051508

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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- (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. \$ 20,855 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 X NO _____ If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.
DOBSON PLAZA INC #0008136 07/01/2011
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period. \$ 231,888
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. \$ 11,096 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