

		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: 0051508

Facility Name: Dobson Plaza

Address: 120 Dodge Avenue Evanston 60202
Number City Zip Code

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

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mendel S Schneider Telephone Number: 847-933-1274
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 01/01/2025 to 12/31/2025 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) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) See Accountant's Report Attached (Date)
(Print Name and Title)
(Firm Name & Address) Mendel S Schneider & Associates CPA PC
4051 Old Orchard Rd Skokie Illinois 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

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 Dobson Plaza # 0051508 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	<u>97</u>	Skilled (SNF)	<u>97</u>	<u>35,405</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>35,405</u>	7

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	6,931	7,367	1,109		12,761	1,708	450	30,326	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	6,931	7,367	1,109		12,761	1,708	450	30,326	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 85.65%

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 ☒

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 07/01/11

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date 07/01/11 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 97

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 12/31

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

Facility Name & ID Number Dobson Plaza # 0051508 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	213,555	16,872	26,037	256,464		256,464		256,464			1
2	Food Purchase		310,955		310,955	(12,000)	298,955	(1,286)	297,669			2
3	Housekeeping	139,660	5,439	17,901	163,000		163,000		163,000			3
4	Laundry	59,303	19,531		78,834		78,834		78,834			4
5	Heat and Other Utilities			103,941	103,941		103,941		103,941			5
6	Maintenance	101,581		66,163	167,744		167,744		167,744			6
7	Other (specify):*											7
8	TOTAL General Services	514,099	352,797	214,042	1,080,938	(12,000)	1,068,938	(1,286)	1,067,652			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	3,073,467	142,009	45,993	3,261,469		3,261,469		3,261,469			10
10a	Therapy	296,435			296,435		296,435		296,435			10a
11	Activities	163,299	7,026		170,325		170,325		170,325			11
12	Social Services	152,215		27,980	180,195		180,195		180,195			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,685,416	149,035	88,973	3,923,424		3,923,424		3,923,424			16
	C. General Administration											
17	Administrative	215,590			215,590		215,590		215,590			17
18	Directors Fees											18
19	Professional Services			232,400	232,400		232,400	(150,000)	82,400			19
20	Dues, Fees, Subscriptions & Promotions			38,871	38,871		38,871	(16,237)	22,634			20
21	Clerical & General Office Expenses	250,983	68,439	201,358	520,780		520,780	(34,009)	486,771			21
22	Employee Benefits & Payroll Taxes			746,014	746,014	12,000	758,014		758,014			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			21,559	21,559		21,559	(21,559)				25
26	Insurance-Prop.Liab.Malpractice			255,555	255,555		255,555		255,555			26
27	Other (specify):*											27
28	TOTAL General Administration	466,573	68,439	1,495,757	2,030,769	12,000	2,042,769	(221,805)	1,820,964			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,666,088	570,271	1,798,772	7,035,131		7,035,131	(223,091)	6,812,040			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			4,625	4,625		4,625	146,067	150,692			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							284,230	284,230			32
33	Real Estate Taxes			563,929	563,929		563,929		563,929			33
34	Rent-Facility & Grounds			1,020,000	1,020,000		1,020,000	(1,020,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			95,000	95,000		95,000	(95,000)				36
37	TOTAL Ownership			1,683,554	1,683,554		1,683,554	(684,703)	998,851			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,511		67,511		67,511		67,511			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			521,313	521,313		521,313		521,313			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		67,511	521,313	588,824		588,824		588,824			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,666,088	637,782	4,003,639	9,307,509		9,307,509	(907,794)	8,399,715			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	(43,149)	30		9
10	Interest and Other Investment Income	(5,291)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,286)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(21,559)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(32,239)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(150,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(95,000)	36		24
25	Fund Raising, Advertising and Promotional	(16,237)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,081)	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)	\$ (366,842)		\$	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)	(540,952)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (540,952)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (907,794)		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			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ 0	20
2	Other Expenses Related to Lobbying Activities		
3			
4			
5			
6			
7			
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9			
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48			
49	Total	0	

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	\$ 1,020,000	Dobson Plaza Inc	100.00%	\$	\$ (1,020,000)	1
2	V	30	Depreciation		Dobson Plaza Inc		189,216	189,216	2
3	V	32	Interest		Dobson Plaza Inc		289,521	289,521	3
4	V	21	Office				311	311	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,020,000			\$ 479,048	\$ * (540,952)	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	Birchwood Plaza Inc	Chicago, Illinois			Dobson Plaza Inc	Evanston	Bldg Rental	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

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		Adm	99.00		40	100.00	Salary	\$ 180,000	17-1	1
2	Barak Kohn		Adm Consultant			40	100.00	Salary	35,590	17-1	2
3	Cynthia Kohn		Bkkpg		57,000	25	50.00	Salary	51,504	22-1	3
4	Rebecca Kohn		Cons		53,400	25	50.00	Salary	63,240	22-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 330,334		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

Ending: 2/31/2025

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

Ending: 2/31/2025

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	Fifth Third Bank		X	Mortgage		12/5/19	\$ 4,500,000	\$ 3,813,919	12/5/29	Prime	\$ 289,521	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,500,000	\$ 3,813,919			\$ 289,521	9	
	B. Non-Facility Related*												
10	Interest Income										(5,291)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (5,291)	14	
15	TOTALS (line 9+line14)						\$ 4,500,000	\$ 3,813,919			\$ 284,230	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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dobson Plaza COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051508

CONTACT PERSON REGARDING THIS REPORT Kathleen McNamara

TELEPHONE 847-675-3585 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 10-25-113-043-0000	Facility	\$ 545,552.04	\$ 545,552.04
2. 10-25-220-015-0000	Facility	\$ 633.18	\$ 633.18
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 546,185.22	\$ 546,185.22

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 (X) (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 (X) (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 (X) 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:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	18,167		1966		\$ 80,509	
2							
3	TOTALS	18,167				\$ 80,509	

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	58		1966	1966	\$ 251,171	\$	35	\$	\$	251,171	4
5	37			1987	930,705		40	23,268	23,268	893,377	5
6	2			1971	11,147		35			11,147	6
7											7
8											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											12
13	Landscaping			1988	6,905		10			6,905	13
14	Sewer			1988	5,650		25			5,650	14
15	Fencing			1988	1,878		15			1,878	15
16											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	Remodeling of Ancillary Areas			1997	516,118		40	13,374	13,374	387,846	25
26	Canopy Sign			1999	8,000		39	205	205	5,407	26
27											27
28	Fire Dampers/Air Intake			2000	10,515		27.5	382	382	9,789	28
29	Elevator upgrade-Air Intakes			2000	18,221		27.5			23,361	29
30	Elevator upgrade			2001	18,221		27.5	690	690	17,106	30
31	Carpeting			2001	23,914		27.5			23,914	31
32	Heat Exchanger/Fire Supression System			2003	11,572		27.5	421	421	9,569	32
33	Hydraulic Elevator Pump			2006	10,772		27.5	392	392	7,758	33
34	Bathroom Fixtures/Lighting/Carpentry/Halls/Wallpaper			2006	29,463		27.5	1,071	1,071	20,991	34
35	Nursing Station/Bathroom/Plumbing/Flooring/Root			2007	53,627		27.5	1,950	1,950	36,155	35
36	Beauty Shop Drywall/Cabintry/Plumbing/Tile			2007	7,287		27.5	264	264	4,750	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:

01/01/2025

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	Metal Exit Doors/Fire Retardent Cement	2008	\$ 8,404	\$	27.5	\$ 306	\$ 306	\$ 5,473	37
38	PT,AAD,Dayrooms-Drywall,Flooring,Studs,Joist	2008	19,380		27.5	705	705	12,543	38
39	Bathrooms-Tile,Floor,Drywall,Paint,Paper	2008	15,425		27.5	561	561	9,895	39
40	Repipe Kitchen Water Lines	2008	2,065		27.5	75	75	1,330	40
41	Flood Service Counter/Cabinet/Flooring	2008	3,015		27.5	109	109	1,914	41
42	Lower Level Bathroom Project	2008	26,300		27.5	956	956	16,387	42
43	Lower Level Nurses Station	2008	12,500		27.5	455	455	7,792	43
44	Upper Roof Replacement	2008	18,500		27.5	673	673	11,525	44
45	Carpeting	2008	11,259		10			11,259	45
46	Driveway Parking Lot	2008	18,807		27.5			18,807	46
47	Therapy Room Wall/Shelving/Carpentry/Doors	2009	5,530		27.5	201	201	3,400	47
48	2nd Floor Roofs/5 Ton A/C Condensor	2009	11,025		27.5	443	443	7,424	48
49	Security System/Cables/Wanderguard Wiring	2009	5,671		27.5	206	206	3,432	49
50	Carpentry/Recessed Lighting/Wiring 28 Outlets	2009	7,975		27.5	290	290	4,725	50
51	Sump Pump Motor & Pipelines	2009	3,700		27.5	135	135	2,201	51
52	Ceramic Floor/Carpentry/Closet/Intercom Cable	2009	2,919		27.5	108	108	1,733	52
53	Carpeting/Window Treatments	2009	7,403		10			7,403	53
54	Outlets/Cable Wall Mounts	2010	8,730		27.5	317	317	5,006	54
55	Nurses Station Built Ins/Drywall	2010	5,011		10	215	215	3,198	55
56	Delayed Elevator Egress Locks	2010	3,868		27.5	141	141	2,203	56
57	Wallpaper/Carpeting/Cove Base/Base Boards	2010	12,741		10			12,741	57
58	Sump Pump	2010	2,600		27.5	281	281	4,274	58
59	Weil Pump	2011	5,119		10			5,119	59
60	2nd Floor Nsg Station/Carpentry/Built Ins/Closet/Rails	2011	3,015		27.5	205	205	3,015	60
61	1st Floor Nsg Station Sockets/Lighting/Built In Kitchen Cabinet								61
62	Bathroom Work/Library Duct & Seal Windows/1st floor Bathroom								62
63	New Dry Wall/Soffits/Concrete	2012	48,520		27.5	1,845	1,845	24,831	63
64									64
65	A/C For Dining Room	2012	3,120		27.5	113	113	1,521	65
66	Wiring	2014	5,597		27.5	203	203	2,364	66
67	Security System Upgrades	2015	3,100		15	178	178	3,287	67
68	Elevator Retractable Ladder & Wiring	2015	4,026		27.5	147	147	1,506	68
69	2nd Floor Corridor & Dayroom Flooring	2015	18,961		27.5	690	690	6,924	69
70	TOTAL (lines 4 thru 69)		\$ 2,510,026	\$		\$ 51,575	\$ 51,575	\$ 2,210,580	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:

01/01/2025

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		\$ 2,510,026	\$		\$ 51,575	\$ 51,575	\$ 2,210,580	1
2	Hot Water Tank	2016	10,253		27.5	373	373	3,621	2
3	1st Floor Corridor Carpeting	2016	3,694		27.5	134	134	1,301	3
4	Elevator Main control Valve	2016	6,500		27.5	236	236	2,252	4
5	Nurses Station	2017	14,300		27.5	520	520	4,658	5
6	Kohler Generator	2017	50,000		27.5	1,818	1,818	16,135	6
7	2nd Floor Dayroom PVT Flooring & Cove Base	2017	5,424		27.5	197	197	1,732	7
8	3rd Floor Corridor Carpeting	2017	5,221		27.5	190	190	1,639	8
9	South Rooging Cooling Heater Unit	2017	14,915		27.5	542	542	4,584	9
10	Shunt Trip Unit in Elevator	2017	5,643		27.5	205	205	1,666	10
11	2019 Improvements:								11
12	1st Floor Day Room Expansion & Renovation								12
13	Renovation of Office and Front Lobby Areas Including Entrances								13
14	Expansion of Basement Physical Therapy Space & Conference								14
15	Room Addition								15
16	Renovation of 2 Residents Room on First Floor	2019	1,618,300		27.5	58,847	58,847	411,929	16
17	Improvements-Contracted Total	2019	33,891		15	2,259	2,259	14,714	17
18	New Signs(TFA Signs),Paneling the Connection Room								18
19	(Hanna Z Interiors),Laminated Lobby Paneling,Carpet								19
20	Tile for Corridor Area								20
21	Marco Welding-Wrought Iron Fence	2020	8,500		15	567	567	3,402	21
22	Stanko Flooring-First Floor Corridor	2020	7,000		15	467	467	2,802	22
23	Sign,Electrical Repair-Contracted Total	2020	30,429		15	2,029	2,029	12,174	23
24									24
25	Install New Wallpaper,Wall Protection,Paint Window Trim	2021	8,000		15	533	533	2,399	25
26	in resident Dining Room								26
27	Second Floor Dining Room Remodeling-Remoce and Install	2022	42,084		15	2,805	2,805	11,220	27
28	Wallpaper								28
29	Disconnect condenser on Roof & Install New One	2023	38,400		15	2,560	2,560	7,680	29
30	Shower Room-Demo & Removal,New Tub & Tile Installation	2023	18,969		15	1,265	1,265	3,795	30
31									31
32	Tile & Porcelin For New Shower	2023	5,535		15	369	369	1,107	32
33	Install New Shower Faucet,Vinyl Acc Door,Grab Bars-3Floor	2023	2,525		15	168	168	504	33
34	TOTAL (lines 1 thru 33)		\$ 4,439,609	\$		\$ 127,659	\$ 127,659	\$ 2,719,894	34

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

****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	\$ 186,988	\$	\$ 16,571	\$ 16,571	10	\$ 186,988	71
72	Current Year Purchases	3,148	3,148	315	(2,833)	10	315	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 190,136	\$ 3,148	\$ 16,886	\$ 13,738		\$ 187,303	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	Facility	17 Acura MDX	2016	\$ 65,357	\$	\$	\$	5	\$ 65,357	76
77										77
78										78
79										79
80	TOTALS			\$ 65,357	\$	\$	\$		\$ 65,357	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,867,820	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 193,841	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 150,692	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (43,149)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,984,540	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?
16. Rental Amount for movable equipment: \$ Description:
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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

* 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.

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	\$

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				67,511		67,511	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			\$		\$	\$ 67,511		\$ 67,511	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,927,154	\$ 3,013,047	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,058,924	1,058,924	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	176,962	176,962	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,079,785	8
9	Other(specify): Due from Others	1,845,864	3,071,996	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,008,904	\$ 8,400,714	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		2,614,520	15
16	Equipment, at Historical Cost	94,077	342,292	16
17	Accumulated Depreciation (book methods)	(66,872)	(3,788,235)	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): 501K Life Ins Contracts	303,719		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 330,924	\$ 1,331,367	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,339,828	\$ 9,732,081	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 244,043	\$ 244,043	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	86,138	86,138	28
29	Short-Term Notes Payable	638	638	29
30	Accrued Salaries Payable	158,980	158,980	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,056	14,056	31
32	Accrued Real Estate Taxes(Sch.IX-B)		557,110	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Acc Mgmt Fee	194,872	194,872	36
37	Due to Others	92,966	92,966	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 791,693	\$ 1,348,803	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,813,919	40
41	Bonds Payable			41
42	Deferred Compensation	1,177,131	1,177,131	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,177,131	\$ 4,991,050	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,968,824	\$ 6,339,853	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,371,004	\$ 3,392,228	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,339,828	\$ 9,732,081	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,112,838	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,112,838	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,258,166	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	()	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)	\$ 1,258,166	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)	\$ 3,371,004	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Dobson Plaza

0051508

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	\$ 10,560,384	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,560,384	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***	5,291	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,291	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)	\$ 10,565,675	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,080,938	31
32	Health Care	3,923,424	32
33	General Administration	2,030,769	33
	B. Capital Expense		
34	Ownership	1,683,554	34
	C. Ancillary Expense		
35	Special Cost Centers	67,511	35
36	Provider Participation Fee	521,313	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,307,509	40
41	Income before Income Taxes (line 30 minus line 40)**	1,258,166	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,258,166	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,846,065.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,111,564.00	45
46	MMAI-Medicaid is the Primary Payer	294,217.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	4,510,740.00	48
49	Medicare Part A	1,326,726.00	49
50	Other-(specify) Medicare-B	134,165.00	50
51	Other-(specify) Medicare Replacement	336,907.00	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)	\$ 10,560,384	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	1,882	2,150	\$ 131,428	\$ 61.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,584	31,590	1,313,726	41.59	3
4	Licensed Practical Nurses	3,216	3,499	125,980	36.00	4
5	CNAs & Orderlies	59,698	65,239	1,502,333	23.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,504	5,584	296,435	53.09	8
9	Activity Director					9
10	Activity Assistants	7,093	7,266	163,299	22.47	10
11	Social Service Workers	2,328	2,335	152,215	65.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,645	11,791	213,555	18.11	15
16	Dishwashers					16
17	Maintenance Workers	3,598	4,296	101,581	23.65	17
18	Housekeepers	5,898	6,588	139,660	21.20	18
19	Laundry	2,749	3,095	59,303	19.16	19
20	Administrator	2,080	2,080	180,000	86.54	20
21	Assistant Administrator	2,080	2,080	35,590	17.11	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,341	7,564	250,983	33.18	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)	141,696	155,157	\$ 4,666,088 *	\$ 30.07	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	Monthlu	\$ 26,037	1-3	35
36	Medical Director	Monthlu	15,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,513	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	Monthly	27,980	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 75,530		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	790	\$ 39,480	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	790	\$ 39,480		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Charlotte Kohn	Administrator	99	\$ 180,000
Barak Kohn	Asst Adm		35,590
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 215,590
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Mendel Schneider CPA	Accounting		\$ 21,000
Neil Schaum	Accounting		21,475
JAMMA Consulting	MDS Cons		16,870
Jeffrey Slatas	Legal		6,000
Thompson Coburn	Legal		3,910
Gerardo Dean	Legal		9,000
Homeland Security	Asylum Seeking Filing		4,145
CNA Ins	Legal-Adjusted Out		150,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 232,400
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 65,989
Unemployment Compensation Insurance			15,810
FICA Taxes			350,184
Employee Health Insurance			314,031
Employee Meals			12,000
Illinois Municipal Retirement Fund (IMRF)*			
TOTAL (agree to Schedule V, line 22, col.8)			\$ 758,014
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,990
Advertising: Employee Recruitment			2,359
Health Care Worker Background Check (Indicate # of checks performed _____)			80
Patient Background Checks			460
Association Dues (total from pg 22, #4)			
City of Evanston			16,230
Various			1,515
Less: Public Relations Expense		(	)
PAC and Lobbying payments		(	)
All non-allowable advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 22,634
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
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.

\$ 40,693 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.

\$ 521,313

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.

\$ 12,000 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.

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