FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0008136

Facility Name: DOBSON PLAZA

Address: 120 DODGE AVENUE (Number) EVANSTON (City) 60202 (Zip Code)

County: COOK

Telephone Number: (847) 869-7744 **Fax #** (847) 570-0112

HFS ID Number:

Date of Initial License for Current Owners: 10/15/66

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **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 01/01/2010 to 12/31/2010 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) CHARLOTTE KOHN
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(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

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,405	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	97	TOTALS	97	35,405	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,417	8,372	3,121	32,910	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,417	8,372	3,121	32,910	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.95%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/15/66

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 3,121

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	118,203	13,654	58,493	190,350		190,350		190,350			1
2	Food Purchase		150,099		150,099	(10,293)	139,806	(786)	139,020			2
3	Housekeeping	37,984	27,055		65,039		65,039		65,039			3
4	Laundry	32,162	5,476	1,163	38,801		38,801		38,801			4
5	Heat and Other Utilities			68,265	68,265		68,265		68,265			5
6	Maintenance	50,255	5,940	40,265	96,460		96,460		96,460			6
7	Other (specify):*			10,118	10,118		10,118		10,118			7
8	TOTAL General Services	238,604	202,224	178,304	619,132	(10,293)	608,839	(786)	608,053			8
	B. Health Care and Programs											
9	Medical Director			11,750	11,750		11,750		11,750			9
10	Nursing and Medical Records	1,799,514	79,437	35,875	1,914,826		1,914,826		1,914,826			10
10a	Therapy	93,132		500	93,632		93,632		93,632			10a
11	Activities	82,577	17,821	500	100,898		100,898		100,898			11
12	Social Services	34,058		3,840	37,898		37,898		37,898			12
13	CNA Training											13
14	Program Transportation			220	220		220		220			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,009,281	97,258	52,685	2,159,224		2,159,224		2,159,224			16
	C. General Administration											
17	Administrative	179,111			179,111		179,111		179,111			17
18	Directors Fees											18
19	Professional Services			85,750	85,750		85,750	(11,200)	74,550			19
20	Dues, Fees, Subscriptions & Promotions			56,015	56,015		56,015	(38,969)	17,046			20
21	Clerical & General Office Expenses	111,018	18,209	37,830	167,057		167,057		167,057			21
22	Employee Benefits & Payroll Taxes			439,917	439,917	10,293	450,210		450,210			22
23	Inservice Training & Education			4,173	4,173		4,173		4,173			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			8,115	8,115		8,115	(2,009)	6,106			25
26	Insurance-Prop.Liab.Malpractice			80,446	80,446		80,446		80,446			26
27	Other (specify):*											27
28	TOTAL General Administration	290,129	18,209	712,246	1,020,584	10,293	1,030,877	(52,178)	978,699			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,538,014	317,691	943,235	3,798,940		3,798,940	(52,964)	3,745,976			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.

Facility Name & ID#: DOBSON PLAZA **#0008136** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	58,493	
	REPAIRS & MAINTENANCE		0	
			0	58,493
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,163	
			0	1,163
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		20,491	
	ELECTRICITY		27,086	
	WATER		19,717	
	CABLE TV - LOBBY		971	
			0	68,265
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,291	
	PAINTING & DECORATING		2,440	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		22,202	
	ELEVATOR MAINTENANCE & REPAIR		4,922	
	OUTSIDE LABOR		750	
	EXTERMINATING SERVICE		2,786	
	FIRE SERVICE		4,874	
			0	
			0	
			0	
			0	40,265
7	**OTHER**			
	SCAVENGER		10,118	
	SECURITY SERVICE		0	
			0	
			0	10,118
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	11,750	11,750

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	203	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	29,077	
	PHARMACY CONSULTANT	XVIII B 39-2	1,979	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	4,616	
			0	
			0	35,875
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		500	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				500
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	CLERGY		500	500
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,840	
			0	3,840
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DOBSON PLAZA **#0008136** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		220	220
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,071	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	80,679	
			0	85,750
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	23,544	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	7,830	
	CONTRIBUTIONS	VI 20 XIX F	1,191	
	DUES & SUBSCRIPTIONS	XIX F	140	
	LICENSES & PERMITS	XIX F	7,966	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	14,234	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	450	
	PATIENT BACKGROUND CHECKS	XIX F	660	
				56,015
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		592	
	EQUIPMENT REPAIR & MAINTENANCE		8,958	
	OUTSIDE CLERICAL SERVICES		4,837	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		23,443	
	MESSENGER SERVICE		0	
			0	37,830

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	194,158	
	UNEMPLOYMENT COMPENSATION	XIX D	10,144	
	WORKERS COMPENSATION INSURANC	XIX D	53,679	
	HOSPITALIZATION INSURANCE	XIX D	179,435	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,652	
	EMPLOYEE PHYSICAL EXAMS	XIX D	35	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	501 PLAN EXPENSE	XIX D	(2,186)	
	CHICAGO HEAD TAX	XIX D	0	
			0	439,917
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,173	
				4,173
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,106	
	AUTO EXPENSE - DISALLOWED - PAGE 5A VI. LINE 1		2,009	8,115
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		80,446	
				80,446
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **943,235**

DOBSON PLAZA
SCHEDULES
12/31/2010

PG 23 XX. GENERAL INFORMATION QUESTION 12. ONE EMPLOYEE WORKS 50% ACCOUNTS PAYABLE/BOOKKEEPING AND 50% ACTIVITIES

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

TOTAL FOOD PURCHASE	150,099
LESS SALES TAX	(786)
NET FOOD	149,313
TOTAL PATIENT CENSUS	32,910
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	98,730
ADD # EMPLOYEE MEALS/DAY	20
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	7,300
PATIENT MEALS	98,730
ADD EMPLOYEE MEALS	7,300
TOTAL MEALS/YEAR	106,030
NET FOOD	149,313
DIVIDE TOTAL MEALS/YEAR	106,030
COST PER MEAL	1.41
TIME EMPLOYEE MEALS	7,300
EMPLOYEE MEAL RECLASSIFICATION	**10,293**

PROFESSIONAL FEES
PAGE 21 XIX. C.

ALPHA DATA SERVICES	DATA PROCESSING	4,471
VISIONSHARE-MUTUAL OF OMAHA	DATA PROCESSING	600
RICHARD PEELO	MEDICARE COST REPORT	3,000
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	18,850
MYRON TUSHBAI	ACCOUNTING	2,662
UHY ADVISOR	VALUATION CONSULTANT	11,200
PROPERTY VALUATION SERVICE	APPRAISAL	5,700
MUCH SHELIST	LEGAL	22,264
KEITH GOLDBERG	LEGAL	400
REIFF SCHRAMM KANTER	LEGAL	435
PERSONNEL PLANNING	UNEMPLOYMENT CONSULTANT	634
ECONOCARE	PURCHASING CONSULTANT	1,962
ADVANTAGE BENEFITS CONSULTANT	PENSION PLAN CONSULTANT	1,572
ISRAEL LICHTSHEIN	PURCHASING CONSULTANT	12,000
	PROFESSIONAL FEES	**85,750**

TRANSPORTATION - STAFF
PAGE 3 SCHEDULE V COLUMN 3 LINE 25

	NAME	DEPT	PURPOSE	MISC	AUTO ALLOW J GRODETZ
1.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
1.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	1.50	
2.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
2.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	350.92	
2.09	SAM'S CLUB	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	70.12	
3.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
3.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activiities	216.54	
3.09	SAM'S CLUB	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	48.33	
4.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
5.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
5.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	411.71	
5.09	SAM'S CLUB		Gasoline for facilty banking, maintenance, marketing & activities	36.77	
6.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
6.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	118.65	
6.09	SAM'S CLUB		Gasoline for facilty banking, maintenance, marketing & activities	43.88	
7.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
7.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	202.56	
7.09	SAM'S CLUB	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	46.39	
7.09	SHALOM ZUPNICK		Gasoline for facilty banking, maintenance, marketing & activities	100.00	
8.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
8.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	368.37	
9.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
9.09	CHASE CARD	FACILTY	Gasoline for facilty banking, maintenance, marketing & activities	128.59	
9.09	SAM'S CLUB	FACILTY	Gasoline for facilty banking, maintenance, marketing & activities	87.01	
9.09	SEC OF STATE		LICENSE	79.00	
9.09	CHASE CARD	FACILTY	Gasoline for facilty banking, maintenance, marketing & activities	2.00	
10.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
10.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	43.81	
10.09	SAM'S CLUB	FACILTY	Gasoline for facilty banking, maintenance, marketing & activities	71.73	
10.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	25.00	
10.09	ISRAEL LICHTSHEIN		Gasoline for facilty banking, maintenance, marketing & activities	89.00	
11.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
11.09	CHASE CARD	FACILTY	Gasoline for facilty banking, maintenance, marketing & activities	67.76	
11.09	MARCELLA C		Gasoline for facilty banking, maintenance, marketing & activities	23.00	
11.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	13.00	
11.09	PETTY CASH	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	44.25	
12.09	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
12.09	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	95.96	
12.09	PETTY CASH	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	5.00	
12.06	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	122.77	
			TOTAL STAFF TRANSPORTATION:	**2,913.62**	**4,361.58** **7,275.20**

EDUCATION AND SEMINARS
PAGE 3 SCHEDULE V COLUMN 3 LINE 23

DATE	SPONSOR OF SEMINAR	PURPOSE OF SEMINAR	ATTENDEES	LOC	COST
2010	CONCORDIA UNIVERSITY CHICAGO	MASTERS IN GERONTOLOGY PROGRAM	CATHY SINGER	IL	2,968.00
6/16/10	IL COUNCIL ON LONG TERM CARE	MDS 3.0 GETTING STARTED	CHARLOTTE KOHN	IL	525.00
			PAMELA SEEFURTH		
			ANNETTE SALTZMAN		
7/29/10	IL COUNCIL ON LONG TERM CARE	THE NEW RUGS IV - STARTING OVER	CHARLOTTE KOHN	IL	290.00
			PAMELA SEEFURTH		
10/5/10	IL COUNCIL ON LONG TERM CARE	NEW OBRA INFECTION PROTECTION REGULATIONS	CHARLOTTE KOHN	IL	330.00
			PAMELA SEEFURTH		
12/10	IL HEALTH CARE ASSOCIATION	MDS 3.0 WEBINAR	PAMELA SEEFURTH	IL	60.00
			ANNETTE SALTZMAN		
			MARIE CHRISTINE FOX		
			IRELLE GANZON		
					4,173.00

Facility Name & ID Number DOBSON PLAZA #0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			91,120	91,120		91,120	(10,369)	80,751			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,164	155,164		155,164	(40,748)	114,416			32
33	Real Estate Taxes			159,431	159,431		159,431		159,431			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			2,456	2,456		2,456		2,456			36
37	TOTAL Ownership			408,171	408,171		408,171	(51,117)	357,054			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,990	100,564	247,554		247,554		247,554			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,108	53,108		53,108		53,108			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		146,990	153,672	300,662		300,662		300,662			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,538,014	464,681	1,505,078	4,507,773		4,507,773	(104,081)	4,403,692			45

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

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	(10,369)	30		9
10	Interest and Other Investment Income	(40,727)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(786)	2		13
14	Non-Care Related Interest	(21)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,009)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,191)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,544)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,234)	20		28
29	Other-Attach Schedule	(11,200)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (104,081)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (104,081)		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

DOBSON PLAZA

ID# 0008136

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	UHY ADVISOR-VALUATION CONSULTANT	$ -11200	19	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**	(11,200)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA **#** 0008136 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(786)	0	0	0	0	0	0	0	0	0	0	(786)	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**	(786)	0	0	0	0	0	0	0	0	0	0	(786)	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	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,200)	0	0	0	0	0	0	0	0	0	0	(11,200)	19
20	Fees, Subscriptions & Promotions	(38,969)	0	0	0	0	0	0	0	0	0	0	(38,969)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,009)	0	0	0	0	0	0	0	0	0	0	(2,009)	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**	(52,178)	0	0	0	0	0	0	0	0	0	0	(52,178)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(52,964)	0	0	0	0	0	0	0	0	0	0	(52,964)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA # 0008136 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(10,369)	0	0	0	0	0	0	0	0	0	0	(10,369)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(40,748)	0	0	0	0	0	0	0	0	0	0	(40,748)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	(51,117)	0	0	0	0	0	0	0	0	0	0	(51,117)	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)**	(104,081)	0	0	0	0	0	0	0	0	0	0	(104,081)	45

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		BIRCHWOOD PLAZA INC	CHICAGO, IL			
	SEE ATTACHED					

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								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			$			$	$ *	14

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

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CHARLOTTE KOHN	ADMINISTRATOR	SUPERVISION	0.00	680,691	33	55.00	SALARY	$ 64,971	17-1	1
2	BARAK KOHN	BUILDING ADMIN	SUPERVISION	6.87	46,481	22.5	36.00	SALARY	41,146	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 106,117		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 # 0008136 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X]

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 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

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MB FINANCIAL		X	MORTGAGE	$32,880.35	12/16/04	$ 5,500,000	$ 4,399,055	12/05/19	3.2500	$ 149,832	1
2	LETTER OF CREDIT		X								250	2
3												3
4												4
5	LEXUS		X	AUTO LOAN	$917.43	09/13/06	45,653	7,083	09/13/11	7.6210	1,027	5
	Working Capital											
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	$8,020.16	06/01/09	96,242		06/01/10	4.5000	2,072	6
7	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	$5,979.36	06/01/10	71,752	29,897	06/01/11	4.5000	1,545	7
8	ISRAEL LICHTSHEIN	X		WORKING CAPITAL	$8,750.00	12/12/08	100,000		01/12/09	5.0000	417	8
9	TOTAL Facility Related				$56,547.30		$ 5,813,647	$ 4,436,035			$ 155,143	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							21	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 21	14
15	TOTALS (line 9+line14)						$ 5,813,647	$ 4,436,035			$ 155,164	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.)**

Facility Name & ID Number DOBSON PLAZA # 0008136 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 141,590	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 149,761	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,171	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 151,260	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 159,431	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	121,551	8
	2006	123,662	9
	2007	135,011	10
	2008	140,189	11
	2009	149,761	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOBSON PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0008136

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-113-043-0000	NURSING HOME	$ 147,912.94	$ 147,912.94
2.	10-25-220-015-0000	NURSING HOME	$ 1,847.94	$ 1,847.94
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 149,760.88	$ 149,760.88

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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? [X] (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? [X] (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 [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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	7,728	1966	$ 80,509	1
2					2
3	TOTALS	7,728		$ 80,509	3

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	58		1966	1966	$ 251,171	$	35	$	$	$ 251,171	4
5	33			1987	930,705	38,099	40	23,268	(14,831)	544,357	5
6	2			1971	11,147		8-12			11,147	6
7	4			1987	64,011		30	1,067	1,067	9,603	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	RENOVATE NURSING STATION			1986	5,223		20			5,223	12
13	LANDSCAPING			1988	6,905		10			6,905	13
14	LAND IMPROVEMENTS - SEWER			1988	5,650		25	226	226	4,934	14
15	LAND IMPROVEMENTS - FENCING			1988	1,878		15			1,878	15
16	LAND IMPROVEMENTS - PAVING			1988	12,335		20			12,335	16
17	OUTSIDE SIGN			1988	2,473		12			2,473	17
18	SPRINKLER SYSTEM			1988	42,241		25	1,690	1,690	36,898	18
19	HEATING, VENTILATION, & A/C			1988	48,620		20			48,620	19
20	PLUMBING COMPOSITE			1988	63,062		25	2,522	2,522	55,567	20
21	ELECTRICAL WIRING			1988	115,484		20			115,484	21
22	BRICK-ENCLOSED GENERATOR			1989	1,375		25	55	55	1,128	22
23	FENCE - GENERATOR			1989	480		15			480	23
24	CATCH BASIN			1989	5,000		10			5,000	24
25	REMODELLING OF ANCILLARY AREAS			1997	534,985	16,180	40	13,374	(2,806)	187,236	25
26	CANOPY SIGN			1999	8,000	205	39	205		2,332	26
27	ELEVATOR REPAIR			1999	1,990	51	39	51		572	27
28	FIRE DAMPERS / AIR INTAKES			2000	10,515	382	27.5	382		4,059	28
29	ELEVATOR UPGRADE / AIR INTAKES			2000	28,259	1,028	27.5	1,028		10,409	29
30	ELEVATOR UPGRADE			2001	18,977	690	27.5	690		6,756	30
31	CARPETING			2001	25,597		10	2,560	2,560	24,320	31
32	HEAT EXCHANGER / FIRE SUPPRESSION SYSTEM			2003	11,572	421	27.5	421		3,254	32
33	HYDRAULIC ELEVATOR PUMP			2006	10,772	392	27.5	392		1,878	33
34	BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER			2006	29,463	1,071	27.5	1,071		4,926	34
35	NURSG STN/BATHRMS/PLUMBG/FLOORING/ROOF FASCIA			2007	53,627	1,949	27.5	1,949		6,905	35
36	BEAUTY SHOP DRYWALL,CABINETRY,PLUMBING,TILE			2007	7,287	265	27.5	265		784	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 # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	METAL EXIT DOORS / FIRE RETARDANT CEMENT	2008	$ 8,404	$ 306	27.5	$ 306	$	$ 883	37
38	PT,AAD,DAYRMS-DRYWALL,FLOORING,STUDS,JOIST	2008	19,380	705	27.5	705		1,968	38
39	BATHRMS:TILE,FLOOR,DRYWALL,PAINT,PAPER,FIXTURI	2008	15,425	561	27.5	561		1,480	39
40	REPIPE KITCHEN WATER LINES	2008	2,065	75	27.5	75		205	40
41	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	110	27.5	110		279	41
42	LOWER LEVEL:REMOVE DOOR,WALL & BATHRM/ENLARGE ROOM & ADD NEW BATHROOM /DRYWALL/SOFFIT/WALLPAPER/PAINT/F								42
43	& NURSING STATION BUILT-IN CABINETRY/COUNTERTO	2008	38,800	1,411	27.5	1,411		3,014	43
44	ROOF	2008	18,500	673	27.5	673		1,430	44
45	CARPETING	2008	11,259	1,283	10	1,126	(157)	3,381	45
46	DRIVEWAY/PARKINGLOT	2008	18,807	1,254	15	1,254		3,134	46
47	THERAPY ROOM WALL/SHELVING/CARPENTRY/6 DOORS	2009	5,530	201	27.5	201		385	47
48	ROOF/AC/CABLES/WIRING/SECURITY SYST/WINDOWS	2009	17,996	655	27.5	655		1,096	48
49	CARPENTRY/RECESSED LIGHTING/OUTLETS/PIPE/SUMP	2009	11,675	425	27.5	425		551	49
50	CERAMIC FLOOR/CARPENTRY/CLOSET/INTERCOM/CABI	2009	2,919	107	27.5	107		113	50
51	CARPETING/WINDOW TREATMENTS/WALLPAPER	2009	13,299	2,128	10	1,330	(798)	1,995	51
52	OUTLETS/CABLE/WALL MOUNTS	2010	8,730	251	27.5	251		251	52
53	BUILT-IN SHELVES/FRAMING/DRYWALL/SINK/COUNTER	2010	5,911	188	27.5	188		188	53
54	DELAYED ELEVATOR EGRESS LOCKS	2010	3,868	88	27.5	88		88	54
55	WALLPAPER/CARPETING/COVE BASE/BASEBOARDS	2010	12,741	7,644	10	637	(7,007)	637	55
56	SUMP PUMP	2010	7,719	59	27.5	59		59	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,546,686	$ 78,857		$ 61,378	$ (17,479)	$ 1,399,610	70

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

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 44,289	$ 2,714	$ 4,344	$ 1,630		$ 27,638	71
72	Current Year Purchases	9,601	7,774	510	(7,264)		510	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 53,890	$ 10,488	$ 4,854	$ (5,634)		$ 28,148	75

D. Vehicle Depreciation (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,	'07 LEXUS RX400H	2006	$ 58,079	$ 1,775	$ 14,519	$ 12,744	4 YRS	$ 58,079	76
77	ACTIVITIES,MAINT,									77
78	& PURCHASING,ETC									78
79										79
80	TOTALS			$ 58,079	$ 1,775	$ 14,519	$ 12,744		$ 58,079	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)	$ 2,739,164	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 91,120	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 80,751	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,369)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,485,837	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	SUNROOM	$ 29,881	92
93			93
94			94
95		$ 29,881	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.

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number DOBSON PLAZA | STATE OF ILLINOIS # 0008136 | Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$		$ 97,227	$		$ 97,227	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			3,337			3,337	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				126,693		126,693	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					20,297		20,297	13
14	TOTAL			$		$ 100,564	$ 146,990		$ 247,554	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.

STATE OF ILLINOIS

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 684,336	$	1
2	Cash-Patient Deposits	26,880		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	793,287		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	4,229		5
6	Prepaid Insurance	46,565		6
7	Other Prepaid Expenses	42,045		7
8	Accounts Receivable (owners or related parties)	787,186		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,384,528	$	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	523,815		15
16	Equipment, at Historical Cost	114,442		16
17	Accumulated Depreciation (book methods)	(1,568,233)		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): NY LIFE INSUR.CONTRACTS	393,401		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,626,215	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,010,743	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 222,898	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,880		28
29	Short-Term Notes Payable	289,980		29
30	Accrued Salaries Payable	52,599		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,884		31
32	Accrued Real Estate Taxes(Sch.IX-B)	151,260		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	172,205		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 922,706	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,146,055		40
41	Bonds Payable			41
42	Deferred Compensation	802,858		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,948,913	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,871,619	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,860,876)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,010,743	$	48

*(See instructions.)

Facility Name & ID Number DOBSON PLAZA **#** 0008136 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,970,402)	1
2	Restatements (describe):		2
3	2009 IL REPLACEMENT TAX	(20,001)	3
4			4
5	ROUNDING	(2)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,990,405)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,030,000	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	(900,471)	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)**	$ 129,529	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,860,876)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,434,473	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,434,473	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	114,420	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 114,420	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	1,990	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)**	$ 1,990	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	40,727	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 40,727	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)**	$ 5,591,610	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	619,132	31
32	Health Care	2,159,224	32
33	General Administration	1,020,584	33
	B. Capital Expense		
34	Ownership	408,171	34
	C. Ancillary Expense		
35	Special Cost Centers	247,554	35
36	Provider Participation Fee	53,108	36
	D. Other Expenses (specify):		
37	LOSS ON SALE OF ASSETS	53,837	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,561,610	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,030,000	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,030,000	43

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

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

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

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

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,908	2,156	$ 89,289	$ 41.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,040	24,301	742,930	30.57	3
4	Licensed Practical Nurses	4,517	5,063	121,287	23.96	4
5	CNAs & Orderlies	53,582	59,104	670,807	11.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,628	1,726	93,132	53.96	8
9	Activity Director	2,142	2,451	42,673	17.41	9
10	Activity Assistants	2,581	2,758	39,904	14.47	10
11	Social Service Workers	1,659	1,690	34,058	20.15	11
12	Dietician					12
13	Food Service Supervisor	504	504	9,603	19.05	13
14	Head Cook	3,152	3,493	39,603	11.34	14
15	Cook Helpers/Assistants	7,058	7,911	68,997	8.72	15
16	Dishwashers					16
17	Maintenance Workers	3,987	4,598	50,255	10.93	17
18	Housekeepers	3,917	4,287	37,984	8.86	18
19	Laundry	3,507	3,871	32,162	8.31	19
20	Administrator	2,088	2,088	64,971	31.12	20
21	Assistant Administrator	1,988	2,169	72,994	33.65	21
22	Other Administrative	1,150	1,150	41,146	35.78	22
23	Office Manager					23
24	Clerical	4,857	5,380	111,018	20.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS/QA/ADMIT	5,617	5,710	175,201	30.68	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,882	140,410	$ 2,538,014 *	$ 18.08	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 58,493	1-3	35
36	Medical Director	O	11,750	9-3	36
37	Medical Records Consultant	N	29,077	10-3	37
38	Nurse Consultant	T	4,616	10-3	38
39	Pharmacist Consultant	H	1,979	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	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)		$ 109,755		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	20	203	10-3	52
53	TOTAL (lines 50 - 52)	20	$ 203		53

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLOTTE KOHN	ADMINISTRATOR	**	$ 64,971
PAM SEEFURTH	ASST ADMIN		72,994
BARAK KOHN	OTHER ADMIN	**	41,146
** BY ATTRIBUTION 100% KOHN FAMILY OWNED			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 179,111

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		85,750
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 85,750

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,679
Unemployment Compensation Insurance	10,144
FICA Taxes	194,158
Employee Health Insurance	179,435
Employee Meals	10,293
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,652
EMPLOYEE PHYSICAL EXAMS	35
PENSION/PROFIT SHARING PLANS	(2,186)
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 450,210

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	7,830
Health Care Worker Background Check	450
(Indicate # of checks performed 12)	
Patient Background Checks 66	660
TRUST/FRANCHISE/CONTRIB/ETC	1,191
MARKETING/ADV/PROMO	37,778
LICENSES/DUES/SUBSCRIPTIONS	7,111
TRUST/FRANCHISE/CONTRIB/ETC	(1,191)
Less: Public Relations Expense	(0)
Non-allowable advertising	(23,544)
Yellow page advertising	(14,234)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,046

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number DOBSON PLAZA **#** 0008136 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,104** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **53,108**
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? **YES** 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. $ **10,293** 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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.