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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0051508

Facility Name: DOBSON PLAZA NURSING & REHAB CENTER LLC

Address: 120 DODGE (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: 05/01/2011

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	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 01/01/2011 to 12/31/2011 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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	21,986	8,666	3,007	33,659	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,986	8,666	3,007	33,659	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.07%

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 07/01/2011

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

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 3,007

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: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CE] # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	134,866	14,162	55,622	204,650		204,650		204,650			1
2	Food Purchase		148,856		148,856	(9,928)	138,928	(1,203)	137,725			2
3	Housekeeping	41,791	27,933		69,724		69,724		69,724			3
4	Laundry	20,594	5,177	2,559	28,330		28,330		28,330			4
5	Heat and Other Utilities			74,256	74,256		74,256		74,256			5
6	Maintenance	51,153	2,563	38,053	91,769		91,769		91,769			6
7	Other (specify):*			8,236	8,236		8,236		8,236			7
8	**TOTAL General Services**	248,404	198,691	178,726	625,821	(9,928)	615,893	(1,203)	614,690			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,869,312	82,852	19,214	1,971,378		1,971,378		1,971,378			10
10a	Therapy	98,801	1,769	10,168	110,738		110,738		110,738			10a
11	Activities	101,904	11,504	500	113,908		113,908		113,908			11
12	Social Services	32,983		3,840	36,823		36,823		36,823			12
13	CNA Training											13
14	Program Transportation			253	253		253		253			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,103,000	96,125	45,975	2,245,100		2,245,100		2,245,100			16
	C. General Administration											
17	Administrative	301,476			301,476		301,476		301,476			17
18	Directors Fees											18
19	Professional Services			42,477	42,477		42,477	(3,762)	38,715			19
20	Dues, Fees, Subscriptions & Promotions			59,245	59,245		59,245	(36,253)	22,992			20
21	Clerical & General Office Expenses	117,447	16,606	35,444	169,497		169,497		169,497			21
22	Employee Benefits & Payroll Taxes			455,623	455,623	9,928	465,551		465,551			22
23	Inservice Training & Education			10,377	10,377		10,377		10,377			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			5,943	5,943		5,943		5,943			25
26	Insurance-Prop.Liab.Malpractice			77,885	77,885		77,885		77,885			26
27	Other (specify):*											27
28	**TOTAL General Administration**	418,923	16,606	686,994	1,122,523	9,928	1,132,451	(40,015)	1,092,436			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,770,327	311,422	911,695	3,993,444		3,993,444	(41,218)	3,952,226			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 NURSING & REHAB CENTER #0051508 **Report Period Beginning: 01/01/2011** **Ending: 12/31/2011**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	55,476	
	REPAIRS & MAINTENANCE		146	
			0	55,622
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,559	
			0	2,559
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		19,762	
	ELECTRICITY		29,701	
	WATER		23,489	
	CABLE TV - LOBBY		1,304	
			0	74,256
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,972	
	PAINTING & DECORATING		8,651	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		17,247	
	ELEVATOR MAINTENANCE & REPAIR		4,100	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,496	
	FIRE SERVICE		3,587	
			0	
			0	
			0	
			0	38,053
7	**OTHER**			
	SCAVENGER		8,086	
	SECURITY SERVICE		150	
			0	
			0	8,236
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	13,587	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	5,627	
			0	
			0	19,214
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	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	10,168	
				10,168
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	CLERGY		500	500
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,840	
				3,840
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC #0051508 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		253	253
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,564	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	36,913	
			0	42,477
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	20,694	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	4,935	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	0	
	LICENSES & PERMITS	XIX F	17,017	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	15,284	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	275	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F	1,040	
				59,245
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		5,566	
	EQUIPMENT REPAIR & MAINTENANCE		12,039	
	OUTSIDE CLERICAL SERVICES		4,171	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		13,668	
	MESSENGER SERVICE		0	
			0	35,444

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	211,932	
	UNEMPLOYMENT COMPENSATION	XIX D	14,517	
	WORKERS COMPENSATION INSURANC	XIX D	35,353	
	HOSPITALIZATION INSURANCE	XIX D	192,391	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,545	
	EMPLOYEE PHYSICAL EXAMS	XIX D	910	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
	501 PLAN EXPENSE	XIX D	(2,025)	455,623
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		10,377	
				10,377
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,943	
				5,943
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		77,885	
				77,885
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **911,695**

DOBSON PLAZA NURSING & REHAB CENTER LLC **PG 23 XX. GENERAL INFORMATION QUESTION 12.** ONE EMPLOYEE WORKS 50% ACCOUNTS PAYABLE/BOOKKEEPING AND 50% ACTIVITIES
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	148,856
LESS SALES TAX	(1,203)
NET FOOD	147,653
TOTAL PATIENT CENSUS	33,659
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	100,977
ADD # EMPLOYEE MEALS/DAY	20
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	7,300
PATIENT MEALS	100,977
ADD EMPLOYEE MEALS	7,300
TOTAL MEALS/YEAR	108,277
NET FOOD	147,653
DIVIDE TOTAL MEALS/YEAR	108,277
COST PER MEAL	1.36
TIME EMPLOYEE MEALS	7,300
EMPLOYEE MEAL RECLASSIFICATION	**9,928**

PROFESSIONAL FEES
PAGE 21 XIX. C.

ALPHA DATA SERVICES	DATA PROCESSING	4,764
VISIONSHARE-MUTUAL OF OMAHA	DATA PROCESSING	800
RICHARD PEELO	MEDICARE COST REPORT	3,000
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	19,450
MYRON TUSHBAI	ACCOUNTING	2,762
KEITH GOLDBERG	*DISALLOWED PG 5 LNE 29-COLLECTIONS	3,562
SYLVESTER LAW FIRM	*DISALLOWED PG 5 LNE 29-COLLECTIONS	200
MUCH SHELIST	LEGAL	3,271
REIFF SCHRAMM KANTER	REAL ESTATE LEGAL	2,762
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULTANT	600
ADVANTAGE BENEFITS CONSULTANT	PENSION PLAN CONSULTANT	1,306
	PROFESSIONAL FEES	**42,477**

TRANSPORTATION - STAFF
PAGE 3 SCHEDULE V COLUMN 3 LINE 25

	NAME	PURPOSE	MISC	AUTO ALLOW J GRODETZ	
JAN	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		323.08	
	CHASE CARD	Gasoline for facilty banking, maintenance, marketing & activities	58.89		
FEB	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		323.08	
	PETTY CASH	Gasoline for facilty banking, maintenance, marketing & activities	56.00		
MAR	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		323.08	
	CHASE CARD	Gasoline for facilty banking, maintenance, marketing & activiities	79.93		
APR	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		484.62	
	CHASE CARD	Gasoline for facilty banking, maintenance, marketing & activities	106.60		
MAY	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		323.08	
	CHASE CARD	Gasoline for facilty banking, maintenance, marketing & activiities	485.91		
JUN	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		387.70	
	PETTY CASH	Gasoline for facilty banking, maintenance, marketing & activities	60.00		
	CHASE CARD	Gasoline for facilty banking, maintenance, marketing & activities	132.40		
JUL	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		258.46	
AUG	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		323.08	
	CHASE CARD	Gasoline for facilty banking, maintenance, marketing & activities	157.00		
SEP	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		484.62	
	CHASE CARD	Gasoline for facilty banking, maintenance, marketing & activities	298.56		
OCT	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		323.08	
	CHASE CARD	Gasoline for facilty banking, maintenance, marketing & activities	123.29		
NOV	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		323.08	
	CHASE CARD	Gasoline for facilty banking, maintenance, marketing & activities	141.51		
DEC	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE		323.08	
	CHASE CARD	Gasoline for facilty banking, maintenance, marketing & activities	43.31		
		TOTAL STAFF TRANSPORTATION:	**1,743.40**	**4,200.04**	**5,943.44**

EDUCATION AND SEMINARS
PAGE 3 SCHEDULE V COLUMN 3 LINE 23

DATE	SPONSOR	LOCATION	TOPIC	ATTENDEES	COST
2011	CONCORDIA UNIV CHICAGO	IL	MASTERS IN GERONTOLOGY PROGRAM	CATHY SINGER	10,053
FEB	FOOD SERVICE EDUCATION	IL	FOOD SERVICE SEMINAR	ANNETTE SALTZMAN	95
JUN	ICLTC	IL	WRITING WINNING IDRs & OTHER LEGAL ISSUES	CHARLOTTE KOHN	145
OCT	INR SEMINARS	IL	FOOD SERVICE SEMINAR	ANNETTE SALTZMAN	84
			TOTAL EDUCATION AND SEMINARS		**10,377**

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC #0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			91,096	91,096		91,096	(24,711)	66,385			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			149,220	149,220		149,220	(32,991)	116,229			32
33	Real Estate Taxes			232,132	232,132		232,132		232,132			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			2,693	2,693		2,693		2,693			36
37	**TOTAL Ownership**			475,141	475,141		475,141	(57,702)	417,439			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,882	95,012	204,894		204,894		204,894			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**		109,882	148,120	258,002		258,002		258,002			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,770,327	421,304	1,534,956	4,726,587		4,726,587	(98,920)	4,627,667			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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(24,711)	30		9
10	Interest and Other Investment Income	(31,054)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,203)	2		13
14	Non-Care Related Interest	(1,937)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(275)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,694)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(15,284)	20		28
29	Other-Attach Schedule Disallowed legal_collections	(3,762)	19		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (98,920)		$	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))**	$ (98,920)		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

STATE OF ILLINOIS

DOBSON PLAZA NURSING & REHAB CENTER LLC

ID# 0051508

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DISALLOWED LEGAL-COLLECTIONS	$ (3,762)	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**	(3,762)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,203)	0	0	0	0	0	0	0	0	0	0	(1,203)	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**	(1,203)	0	0	0	0	0	0	0	0	0	0	(1,203)	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	(3,762)	0	0	0	0	0	0	0	0	0	0	(3,762)	19
20	Fees, Subscriptions & Promotions	(36,253)	0	0	0	0	0	0	0	0	0	0	(36,253)	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(40,015)	0	0	0	0	0	0	0	0	0	0	(40,015)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,218)	0	0	0	0	0	0	0	0	0	0	(41,218)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(24,711)	0	0	0	0	0	0	0	0	0	0	(24,711)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,991)	0	0	0	0	0	0	0	0	0	0	(32,991)	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**	(57,702)	0	0	0	0	0	0	0	0	0	0	(57,702)	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)**	(98,920)	0	0	0	0	0	0	0	0	0	0	(98,920)	45

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
		BIRCHWOOD PLAZA INC	CHICAGO, IL	DOBSON PLAZA INC		REAL ESTATE RENTAL
	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. [X] 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 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				INITIAL YEAR RELATED PARTY TRANSACTIONS ARE COMBINED IN THIS REPORT				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 NURSING & REHAB CE # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	99.00	1,368,490	33	55.00	SALARY	$ 185,756	17-1	1
2	BARAK KOHN	BUILDING ADMIN	SUPERVISION	0.00	47,124	22.5	36.00	SALARY	41,096	17-1	2
3	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	4,000	4	50.00	SALARY	4,786	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 231,638		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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 NURSING & REHAB CEI # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 4,145,589	12/05/19	3.2500	$ 143,692	1
2												2
3												3
4												4
5	LEXUS		X	AUTO LOAN	$917.43	09/13/06	45,653		09/13/11	7.6210	211	5
	Working Capital											
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	$5,979.36	06/01/10	71,752		06/01/11	4.5000	1,545	6
7	MB FINANCIAL		X	LINE OF CREDIT	DEMAND			520,000		PRIME+	1,835	7
8												8
9	TOTAL Facility Related				$39,777.14		$ 5,617,405	$ 4,665,589			$ 147,283	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							1,937	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,937	14
15	TOTALS (line 9+line14)						$ 5,617,405	$ 4,665,589			$ 149,220	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 NURSING & REHAB CENTER LLC # 0051508 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 151,260	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.)		$ 194,850	2
3. Under or (over) accrual (line 2 minus line 1).		$ 43,590	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 196,800	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** $ 8,259 **For** 2007 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (8,258)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 232,132	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	123,662	8
	2007	135,011	9
	2008	140,189	10
	2009	149,761	11
	2010	194,850	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 2010 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOBSON PLAZA NURSING & REHAB CENTER LLC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051508

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-113-043-0000	NURSING HOME	$ 192,843.88	$ 192,843.88
2.	10-25-220-015-0000	NURSING HOME	$ 2,006.28	$ 2,006.28
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 194,850.16	$ 194,850.16

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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).

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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58		1966	1966	$ 251,171	$	35	$	$	$ 251,171	4
5	33			1987	930,705	38,099	40	23,268	(14,831)	567,625	5
6	2			1971	11,147		8-12			11,147	6
7	4			1987	64,011		30	1,067	1,067	10,670	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	5,160	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	38,588	18
19	HEATING, VENTILATION, & A/C			1988	48,620		20			48,620	19
20	PLUMBING COMPOSITE			1988	63,062		25	2,522	2,522	58,089	20
21	ELECTRICAL WIRING			1988	115,484		20			115,484	21
22	BRICK-ENCLOSED GENERATOR			1989	1,375		25	55	55	1,183	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)	200,610	25
26	CANOPY SIGN			1999	8,000	205	39	205		2,537	26
27	ELEVATOR REPAIR			1999	1,990	51	39	51		623	27
28	FIRE DAMPERS / AIR INTAKES			2000	10,515	382	27.5	382		4,441	28
29	ELEVATOR UPGRADE / AIR INTAKES			2000	28,259	1,028	27.5	1,028		11,437	29
30	ELEVATOR UPGRADE			2001	18,977	690	27.5	690		7,446	30
31	CARPETING			2001	25,597		10	1,277	1,277	25,597	31
32	HEAT EXCHANGER / FIRE SUPPRESSION SYSTEM			2003	11,572	421	27.5	421		3,675	32
33	HYDRAULIC ELEVATOR PUMP			2006	10,772	392	27.5	392		2,270	33
34	BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER			2006	29,463	1,071	27.5	1,071		5,997	34
35	NURSG STN/BATHRMS/PLUMBG/FLOORING/ROOF FASCIA			2007	53,627	1,950	27.5	1,950		8,855	35
36	BEAUTY SHOP DRYWALL,CABINETRY,PLUMBING,TILE			2007	7,287	265	27.5	265		1,049	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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	METAL EXIT DOORS / FIRE RETARDANT CEMENT	2008	$ 8,404	$ 306	27.5	$ 306	$	$ 1,189	37
38	PT,AAD,DAYRMS-DRYWALL,FLOORING,STUDS,JOIST	2008	19,380	705	27.5	705		2,673	38
39	BATHRMS:TILE,FLOOR,DRYWALL,PAINT,PAPER,FIXTURI	2008	15,425	561	27.5	561		2,041	39
40	REPIPE KITCHEN WATER LINES	2008	2,065	75	27.5	75		280	40
41	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	109	27.5	109		388	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		4,425	43
44	ROOF	2008	18,500	673	27.5	673		2,103	44
45	CARPETING	2008	11,259	770	10	1,126	356	4,507	45
46	DRIVEWAY/PARKINGLOT	2008	18,807	1,254	15	1,254		4,388	46
47	THERAPY ROOM WALL/SHELVING/CARPENTRY/6 DOORS	2009	5,530	201	27.5	201		586	47
48	ROOF/5-TON AC CONDENSER/WINDOWS	2009	12,325	448	27.5	448		1,202	48
49	SECURITY SYSTEM/CABLES/WANDERGUARD WIRING	2009	5,671	206	27.5	206		548	49
50	CARPENTRY/RECESSED LIGHTING/WIRING 28 OUTLETS	2009	7,975	290	27.5	290		665	50
51	SUMP PUMP MOTOR & PIPELINES	2009	3,700	135	27.5	135		311	51
52	CERAMIC FLOOR/CARPENTRY/CLOSET/INTERCOM/CABI	2009	2,919	108	27.5	108		221	52
53	CARPETING/WINDOW TREATMENTS/WALLPAPER	2009	13,299	1,277	10	1,330	53	3,325	53
54	OUTLETS/CABLE/WALL MOUNTS	2010	8,730	317	27.5	317		568	54
55	NURSING STATION BUILT-INS/DRYWALL/SINK/COUNTER	2010	5,911	215	27.5	215		403	55
56	DELAYED ELEVATOR EGRESS LOCKS	2010	3,868	141	27.5	141		229	56
57	WALLPAPER/CARPETING/COVE BASE/BASEBOARDS	2010	12,741	2,038	10	1,274	(764)	1,911	57
58	SUMP PUMP	2010	7,719	281	27.5	281		340	58
59	WEIL PUMP 2224	2011	5,119	5,119	10	256	(4,863)	256	59
60	2ND FL NURSING STATION / CARPENTRY / BUILT-INS / CLOSET / RAILS / VINYL FLOORING:								60
61		2011	5,647	145	27.5	145		145	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,557,452	$ 77,519		$ 61,501	$ (16,018)	$ 1,461,111	70

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER I# 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 40,310	$ 2,801	$ 4,184	$ 1,383	8-10 YRS	$ 18,752	71
72	Current Year Purchases	11,195	9,001	700	(8,301)	8 YRS	700	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 51,505	$ 11,802	$ 4,884	$ (6,918)		$ 19,452	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMIN, BANKING,	'07 LEXUS RX400H	2006	$ 58,079	$ 1,775	$	$ (1,775)	4 YRS	$ 58,079	76
77	ACTIVITIES,MAINT,									77
78	& PURCHASING,ETC									78
79										79
80	TOTALS			$ 58,079	$ 1,775	$	$ (1,775)		$ 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)	$ 2,747,545	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 91,096	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 66,385	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,711)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,538,642	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.

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

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

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.	/2012	$
13.	/2013	$
14.	/2014	$

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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$		$ 93,275	$		$ 93,275	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			133			133	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			1,604			1,604	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				101,979		101,979	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					7,903		7,903	13
14	TOTAL			$		$ 95,012	$ 109,882		$ 204,894	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 499	$ 986,775	1
2	Cash-Patient Deposits	19,840	33,431	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,566,596	1,671,649	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,383	43,019	6
7	Other Prepaid Expenses	45,079	45,079	7
8	Accounts Receivable (owners or related parties)		802,627	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,673,397	$ 3,582,580	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		507,173	15
16	Equipment, at Historical Cost		109,584	16
17	Accumulated Depreciation (book methods)		(1,645,748)	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	282,897	282,897	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 282,897	$ 1,416,696	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,956,294	$ 4,999,276	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 263,820	$ 269,853	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,840	33,431	28
29	Short-Term Notes Payable	270,000	782,000	29
30	Accrued Salaries Payable	65,842	65,842	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,567	9,899	31
32	Accrued Real Estate Taxes(Sch.IX-B)		196,800	32
33	Accrued Interest Payable			33
34	Deferred Compensation	882,450	882,450	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	205,550	205,550	36
37	DUE TO DOBSON PLAZA INC	1,473		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,716,542	$ 2,445,825	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,883,589	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,883,589	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,716,542	$ 6,329,414	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 239,752	$ (1,330,138)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,956,294	$ 4,999,276	48

***(See instructions.)**

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,860,876)	1
2	Restatements (describe):		2
3	ADJ OUT PRIOR OWNER-DOBSON PLAZA INC	1,860,876	3
4	ADJ IN DOBSON PLAZA NURSING & REHAB LLC	(44)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (44)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,474,723	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) ADJ OUT PRIOR OWNER INCOME	(1,234,927)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 239,796	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)**	$ 239,752	24 *

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 5,811,936	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,811,936	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	152,453	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 152,453	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	1,393	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)**	$ 1,393	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	31,054	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 31,054	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NYL DEATH BENEFIT PAYMENT	204,474	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 204,474	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,201,310	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	625,821	31
32	Health Care	2,245,100	32
33	General Administration	1,122,523	33
	B. Capital Expense		
34	Ownership	475,141	34
	C. Ancillary Expense		
35	Special Cost Centers	204,894	35
36	Provider Participation Fee	53,108	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,726,587	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,474,723	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,474,723	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
LLC TAX RETURN PREPARED ON CASH BASIS

*** **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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1,779	2,016	$ 86,087	$ 42.70	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,779	24,336	757,142	31.11	3
4	Licensed Practical Nurses	4,496	5,100	127,062	24.91	4
5	CNAs & Orderlies	53,573	59,367	687,161	11.57	5
6	CNA Trainees					6
7	Licensed Therapist	1,852	1,898	98,801	52.06	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,143	2,459	43,415	17.66	9
10	Activity Assistants	4,252	4,375	58,489	13.37	10
11	Social Service Workers	1,539	1,634	32,983	20.19	11
12	Dietician					12
13	Food Service Supervisor	1,560	1,560	18,750	12.02	13
14	Head Cook	2,491	2,824	30,669	10.86	14
15	Cook Helpers/Assistants	8,909	9,788	85,447	8.73	15
16	Dishwashers					16
17	Maintenance Workers	4,053	4,727	51,153	10.82	17
18	Housekeepers	4,037	4,548	41,791	9.19	18
19	Laundry	2,088	2,364	20,594	8.71	19
20	Administrator	2,004	2,004	185,756	92.69	20
21	Assistant Administrator	1,840	2,075	69,838	33.66	21
22	Other Administrative	2,079	2,079	45,882	22.07	22
23	Office Manager					23
24	Clerical	4,959	5,564	117,447	21.11	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	216	219	9,676	44.18	31
32	Other Health C: MDS/QA/ADMIT	6,182	6,291	202,184	32.14	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,831	145,228	$ 2,770,327 *	$ 19.08	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	$ 55,476	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	13,587	10-3	37
38	Nurse Consultant	T	5,627	10-3	38
39	Pharmacist Consultant	H	0	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	10,168	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)		$ 100,698		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				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLOTTE KOHN	ADMINISTRATOR	**	$ 185,756
PAM SEEFURTH	ASST ADMIN		69,838
BARAK KOHN	OTHER ADMIN	**	41,096
REBECCA KOHN	OTHER ADMIN	**	4,786
** BY ATTRIBUTION 100% KOHN FAMILY OWNED			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 301,476

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		42,477
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 42,477

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,353
Unemployment Compensation Insurance	14,517
FICA Taxes	211,932
Employee Health Insurance	192,391
Employee Meals	9,928
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,545
EMPLOYEE PHYSICAL EXAMS	910
PENSION/PROFIT SHARING PLANS	(2,025)
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 465,551

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	$ 4,448
Advertising: Employee Recruitment	4,935
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 73	1,040
TRUST/FRANCHISE/CONTRIB/ETC	275
MARKETING/ADV/PROMO	35,978
LICENSES/DUES/SUBSCRIPTIONS	12,569
TRUST/FRANCHISE/CONTRIB/ETC	(275)
Less: Public Relations Expense	(0)
Non-allowable advertising	(20,694)
Yellow page advertising	(15,284)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,992

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)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. $ **29,442** Line **10-2**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
DOBSON PLAZA INC #0008136 07/01/2011

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **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. $ **9,928** 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.