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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0051508

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: 05/01/2011

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	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: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 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) SANFORD BOKOR, 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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	35,502	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	35,502	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			2,928	2,928	8
9	SNF/PED					9
10	ICF	18,622	10,908	1,213	30,743	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,622	10,908	4,141	33,671	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.84%

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 2,887

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: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	111,831	17,669	61,043	190,543		190,543		190,543			1
2	Food Purchase		155,377		155,377	(10,468)	144,909	(922)	143,987			2
3	Housekeeping	44,270	19,232		63,502		63,502		63,502			3
4	Laundry	27,415	8,376	2,816	38,607		38,607		38,607			4
5	Heat and Other Utilities			73,111	73,111		73,111		73,111			5
6	Maintenance	52,267	1,833	44,394	98,494		98,494		98,494			6
7	Other (specify):*			8,132	8,132		8,132		8,132			7
8	TOTAL General Services	235,783	202,487	189,496	627,766	(10,468)	617,298	(922)	616,376			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,929,430	81,064	11,268	2,021,762		2,021,762		2,021,762			10
10a	Therapy	36,667	2,706	4,943	44,316		44,316		44,316			10a
11	Activities	100,743	16,236	1,400	118,379		118,379		118,379			11
12	Social Services	34,062		3,840	37,902		37,902		37,902			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,100,902	100,006	33,451	2,234,359		2,234,359		2,234,359			16
	C. General Administration											
17	Administrative	259,283			259,283		259,283		259,283			17
18	Directors Fees											18
19	Professional Services			40,076	40,076		40,076	(6,126)	33,950			19
20	Dues, Fees, Subscriptions & Promotions			47,592	47,592		47,592	(36,526)	11,066			20
21	Clerical & General Office Expenses	98,486	18,547	26,993	144,026		144,026	(141)	143,885			21
22	Employee Benefits & Payroll Taxes			450,320	450,320	10,468	460,788		460,788			22
23	Inservice Training & Education			2,352	2,352		2,352		2,352			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			5,102	5,102		5,102		5,102			25
26	Insurance-Prop.Liab.Malpractice			64,942	64,942		64,942		64,942			26
27	Other (specify):*											27
28	TOTAL General Administration	357,769	18,547	637,377	1,013,693	10,468	1,024,161	(42,793)	981,368			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,694,454	321,040	860,324	3,875,818		3,875,818	(43,715)	3,832,103			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 **#0051508** **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	61,043	
	REPAIRS & MAINTENANCE		0	
			0	61,043
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,816	
			0	2,816
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		17,800	
	ELECTRICITY		23,855	
	WATER		29,520	
	CABLE TV - LOBBY		1,936	
			0	73,111
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,587	
	PAINTING & DECORATING		3,209	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		15,158	
	ELEVATOR MAINTENANCE & REPAIR		15,061	
	OUTSIDE LABOR		320	
	EXTERMINATING SERVICE		2,624	
	FIRE SERVICE		6,435	
			0	
			0	
			0	
			0	44,394
7	**OTHER**			
	SCAVENGER		8,132	
	SECURITY SERVICE		0	
			0	
			0	8,132
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		221	
	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	4,512	
	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	6,535	
			0	
			0	11,268
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		63	
	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	4,380	
				4,943
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	CLERGY		1,400	1,400
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 **#0051508** **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,071	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	34,005	
			0	40,076
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	18,789	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	3,150	
	CONTRIBUTIONS	VI 20 XIX F	250	
	DUES & SUBSCRIPTIONS	XIX F	0	
	LICENSES & PERMITS	XIX F	6,906	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	17,082	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	405	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	570	
	PATIENT BACKGROUND CHECKS	XIX F	440	
				47,592
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		956	
	EQUIPMENT REPAIR & MAINTENANCE		9,685	
	OUTSIDE CLERICAL SERVICES		4,020	
	PENALTIES / OVERDRAFT CHARGES	VI 18	141	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,191	
	MESSENGER SERVICE		0	
			0	26,993

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	200,348	
	UNEMPLOYMENT COMPENSATION	XIX D	14,710	
	WORKERS COMPENSATION INSURANC	XIX D	44,483	
	HOSPITALIZATION INSURANCE	XIX D	195,795	
	EMPLOYEE BENEFITS - OTHER	XIX D	600	
	EMPLOYEE PHYSICAL EXAMS	XIX D	355	
	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	(5,971)	450,320
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,352	
				2,352
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,102	
				5,102
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		64,942	
				64,942
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **860,324**

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

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

TOTAL FOOD PURCHASE	155,377
LESS SALES TAX	(922)
NET FOOD	154,455
TOTAL PATIENT CENSUS	33,671
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	101,013
ADD # EMPLOYEE MEALS/DAY	20
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	7,320
PATIENT MEALS	101,013
ADD EMPLOYEE MEALS	7,320
TOTAL MEALS/YEAR	108,333
NET FOOD	154,455
DIVIDE TOTAL MEALS/YEAR	108,333
COST PER MEAL	1.43
TIMES EMPLOYEE MEALS	7,320
EMPLOYEE MEAL RECLASSIFICATION	**10,468**

SEMINARS
PAGE 3 SCHEDULE V COLUMN 3 LINES 23

DATE	SPONSOR	PURPOSE OF SEMINAR
4/30/2012	2011 CONCORDIA UNIV CHICAGO	MASTERS IN GERONTOLOGY PROGRAM
6/27/2012	WPS MEDICARE	SEMINAR
12-Jul	INR	
9/4/2012	SAFE FOOD HANDLERS CORP	RECERTIFICATION FOOD SAFETY COURSE
9/24/2012	FRED PRYOR SEMINARS	OZ/OSHA COMPLIANCE 2012
9/7/2012	ICLTC	ANTIPSYCHOTIC DRUG QUALITY MGMT

TRANSPORTATION - STAFF
PAGE 3 SCHEDULE V COLUMN 3 LINES 25

		PURPOSE
JAN	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
JAN	CHASE	Gasoline for facilty banking, maintenance, marketir
JAN	P/C	Gasoline for facilty banking, maintenance, marketir
FEB	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
FEB	CHASE	Gasoline for facilty banking, maintenance, marketir
MAR	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
APR	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
MAY	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
MAY	CHASE	Gasoline for facilty banking, maintenance, marketir
JUN	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
JUN	CHASE	Gasoline for facilty banking, maintenance, marketir
JUL	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
AUG	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
AUG	CHASE	Gasoline for facilty banking, maintenance, marketir
SEP	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
SEP	CHASE	Gasoline for facilty banking, maintenance, marketir
OCT	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
OCT	CHASE	Gasoline for facilty banking, maintenance, marketir

OCT	P/C	Gasoline for facilty banking, maintenance, marketir
NOV	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
NOV	CHASE	Gasoline for facilty banking, maintenance, marketir
NOV	P/C	Gasoline for facilty banking, maintenance, marketir
DEC	PAYROLL - AUTO ALLOWANCE	AUTO ALLOWANCE
		TOTAL TRANSPORTATION - STAFF

)OKKEEPING AND 50% ACTIVITIES

ATTENDEE	LOC	COST
CATHY SINGER	IL	1547
NANCY TAYLOR	IL	220
RENA BERKOWITZ	IL	81
MARCELLA CIORLIERI	IL	160
REBECCA KOHN	IL	179
ANNETTE SATZMAN	IL	165
		2,352

	MISC	GRODETZ	TOTAL
		323.08	
ıg & activities	49.71		
ıg & activities	20.00		
		323.08	
ıg & activities	107.92		
		484.62	
		323.08	
		323.08	
ıg & activities	210.23		
		323.08	
ıg & activities	110.46		
		323.08	
		484.62	
ıg & activities	95.12		
		323.08	
ıg & activities	62.60		
		323.08	
ıg & activities	95.47		

ıg & activities	40.00		
		323.08	
ıg & activities	70.01		
ıg & activities	40.00		
		323.08	
	902	**4,200**	**5,102**

Facility Name & ID Number DOBSON PLAZA #0051508 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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							67,427	67,427			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,588	7,588		7,588	142,671	150,259			32
33	Real Estate Taxes			197,302	197,302		197,302	(478)	196,824			33
34	Rent-Facility & Grounds			945,000	945,000		945,000	(944,601)	399			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			2,528	2,528		2,528		2,528			36
37	**TOTAL Ownership**			1,152,418	1,152,418		1,152,418	(734,981)	417,437			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,822	272,449	378,271		378,271		378,271			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			337,195	337,195		337,195		337,195			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		105,822	609,644	715,466		715,466		715,466			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,694,454	426,862	2,622,386	5,743,702		5,743,702	(778,696)	4,965,006			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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		30		9
10	Interest and Other Investment Income	(74)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(922)	2		13
14	Non-Care Related Interest	(221)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(405)	20		17
18	Fines and Penalties	(141)	21		18
19	Entertainment				19
20	Contributions	(250)	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	(18,789)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(17,082)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(6,126)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,010)		$	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)	(734,686)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (734,686)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (778,696)		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# 0051508

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DISALLOWED LEGAL-COLLECTIONS	$ (1,922)	19	1
2	DISALLOWED LEGAL-CORPORATE MATTERS	(4,204)	19	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**	(6,126)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA **#** 0051508 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	(922)	0	0	0	0	0	0	0	0	0	0	(922)	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**	(922)	0	0	0	0	0	0	0	0	0	0	(922)	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	(6,126)	0	0	0	0	0	0	0	0	0	0	(6,126)	19
20	Fees, Subscriptions & Promotions	(36,526)	0	0	0	0	0	0	0	0	0	0	(36,526)	20
21	Clerical & General Office Expenses	(141)	0	0	0	0	0	0	0	0	0	0	(141)	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**	(42,793)	0	0	0	0	0	0	0	0	0	0	(42,793)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(43,715)	0	0	0	0	0	0	0	0	0	0	(43,715)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA **#** 0051508 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	0	67,427	0	0	0	0	0	0	0	0	0	67,427	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(295)	142,966	0	0	0	0	0	0	0	0	0	142,671	32
33	Real Estate Taxes	0	(478)	0	0	0	0	0	0	0	0	0	(478)	33
34	Rent-Facility & Grounds	0	(944,601)	0	0	0	0	0	0	0	0	0	(944,601)	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**	(295)	(734,686)	0	0	0	0	0	0	0	0	0	(734,981)	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)**	(44,010)	(734,686)	0	0	0	0	0	0	0	0	0	(778,696)	45

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
CHARLOTTE KOHN	99%	BIRCHWOOD PLAZA INC	CHICAGO, IL	DOBSON PLAZA INC		REAL ESTATE
ARTHUR J KOHN	1%				EVANSTON	RENTAL

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	34	RENT	$ 945,000	DOBSON PLAZA INC		$ 399	$ (944,601)	1
2	V	30	SL DEPRECIATION		" "		67,427	67,427	2
3	V	32	INTEREST		" "		142,966	142,966	3
4	V	33	REAL ESTATE TAX		" "		(478)	(478)	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			$ 945,000			$ 210,314	$ * (734,686)	14

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	CHARLOTTE KOHN	ADMINISTRATOR	SUPERVISION	99.00	1,437,105	33	55.00	SALARY	$ 183,989	17-1	1
2	BARAK KOHN	BUILDING ADMIN	SUPERVISION	0.00	48,247	22.5	36.00	SALARY	41,193	17-1	2
3	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00		5.5	50.00	SALARY	23,557	17-1	3
4											4
5											5
6											6
7											7
8											8
9	BY ATTRIBUTION, 100% KOHN FAMILY OWNED										9
10											10
11											11
12											12
13								TOTAL	$ 248,739		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	RELATED PARTY - DOBSON PLAZA INC:						$	$			$	1
2	MB FINANCIAL		X	MORTGAGE	$32,880.35	12/16/04	5,500,000	3,905,901	12/05/19	3.2500	131,604	2
3	MB FINANCIAL		X	LINE OF CREDIT	DEMAND	06/05/11	400,000		06/05/12	PRIME+	5,425	3
4	NATIONAL REPUBLIC BANK		X	LINE OF CREDIT	DEMAND			51,000		PRIME+	5,937	4
5												5
	Working Capital											
6	MB FINANCIAL		X	LINE OF CREDIT	DEMAND	06/05/12		200,000	06/05/12	PRIME+	7,367	6
7												7
8												8
9	TOTAL Facility Related				$32,880.35		$ 5,900,000	$ 4,156,901			$ 150,333	9
	B. Non-Facility Related*											
10	INTEREST-OTHER		X								221	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 221	14
15	TOTALS (line 9+line14)						$ 5,900,000	$ 4,156,901			$ 150,554	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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 196,800	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.)		$ 195,834	2
3. Under or (over) accrual (line 2 minus line 1).		$ (966)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 197,790	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.		$ 196,824	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	135,011	8
	2008	140,189	9
	2009	149,761	10
	2010	194,850	11
	2011	195,834	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 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOBSON PLAZA 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-113-043-0000	NURSING HOME	$ 193,817.45	$ 193,817.45
2.	10-25-220-015-0000	NURSING HOME	$ 2,016.43	$ 2,016.43
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 195,833.88	$ 195,833.88

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	RELATED PARTY - DOBSON PLAZA INC:			$	1
2	NURSING HOME	7,728	1966	80,509	2
3	TOTALS	7,728		$ 80,509	3

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY-DOBSON PLAZA INC:				$	$		$	$	$	4
5	58		1966	1966	251,171		35			251,171	5
6	33			1987	930,705	38,099	40	23,268	(14,831)	590,893	6
7	2			1971	11,147		8-12			11,147	7
8	4			1987	64,011		30	1,067	1,067	11,737	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	5,386	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	40,278	18
19	HEATING, VENTILATION, & A/C			1988	48,620		20			48,620	19
20	PLUMBING COMPOSITE			1988	63,062		25	2,522	2,522	60,611	20
21	ELECTRICAL WIRING			1988	115,484		20			115,484	21
22	BRICK-ENCLOSED GENERATOR			1989	1,375		25	55	55	1,238	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)	213,984	25
26	CANOPY SIGN			1999	8,000	205	39	205		2,742	26
27	ELEVATOR REPAIR			1999	1,990	51	39	51		674	27
28	FIRE DAMPERS / AIR INTAKES			2000	10,515	382	27.5	382		4,823	28
29	ELEVATOR UPGRADE / AIR INTAKES			2000	28,259	1,028	27.5	1,028		12,465	29
30	ELEVATOR UPGRADE			2001	18,977	690	27.5	690		8,136	30
31	CARPETING			2001	25,597		10			25,597	31
32	HEAT EXCHANGER / FIRE SUPPRESSION SYSTEM			2003	11,572	421	27.5	421		4,096	32
33	HYDRAULIC ELEVATOR PUMP			2006	10,772	392	27.5	392		2,662	33
34	BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER			2006	29,463	1,071	27.5	1,071		7,068	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		1,314	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$	$ 1,495	37
38	PT,AAD,DAYRMS-DRYWALL,FLOORING,STUDS,JOIST	2008	19,380	705	27.5	705		3,378	38
39	BATHRMS:TILE,FLOOR,DRYWALL,PAINT,PAPER,FIXTURE	2008	15,425	561	27.5	561		2,602	39
40	REPIPE KITCHEN WATER LINES	2008	2,065	75	27.5	75		355	40
41	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	109	27.5	109		497	41
42	LOWER LEVEL:REMOVE DOOR,WALL & BATHRM/ENLARGE ROOM & ADD NEW BATHROOM/DRYWALL/SOFFIT/WALLPAPER/PAINT/FIXTURES/HANDICAP ACCESIBILITY								42
43	& NURSING STATION BUILT-IN CABINETRY/COUNTERTO	2008	38,800	1,411	27.5	1,411		5,836	43
44	ROOF	2008	18,500	673	27.5	673		2,776	44
45	CARPETING	2008	11,259	770	10	1,126	356	5,633	45
46	DRIVEWAY/PARKINGLOT	2008	18,807	1,254	15	1,254		5,642	46
47	THERAPY ROOM WALL/SHELVING/CARPENTRY/6 DOORS	2009	5,530	201	27.5	201		787	47
48	ROOF/5-TON AC CONDENSER/WINDOWS	2009	12,325	448	27.5	448		1,650	48
49	SECURITY SYSTEM/CABLES/WANDERGUARD WIRING	2009	5,671	206	27.5	206		754	49
50	CARPENTRY/RECESSED LIGHTING/WIRING 28 OUTLETS	2009	7,975	290	27.5	290		955	50
51	SUMP PUMP MOTOR & PIPELINES	2009	3,700	135	27.5	135		446	51
52	CERAMIC FLOOR/CARPENTRY/CLOSET/INTERCOM/CABL	2009	2,919	108	27.5	108		329	52
53	CARPETING/WINDOW TREATMENTS/WALLPAPER	2009	13,299	1,277	10	1,330	53	4,655	53
54	OUTLETS/CABLE/WALL MOUNTS	2010	8,730	317	27.5	317		885	54
55	NURSING STATION BUILT-INS/DRYWALL/SINK/COUNTER	2010	5,911	215	27.5	215		618	55
56	DELAYED ELEVATOR EGRESS LOCKS	2010	3,868	141	27.5	141		370	56
57	WALLPAPER/CARPETING/COVE BASE/BASEBOARDS	2010	12,741	2,038	10	1,274	(764)	3,185	57
58	SUMP PUMP	2010	7,719	281	27.5	281		621	58
59	WEIL PUMP 2224	2011	5,119	5,119	10	768	(4,351)	768	59
60	2ND FL NURSING STATION / CARPENTRY / BUILT-INS / CLOSET / RAILS / VINYL FLOORING:								60
61		2011	5,647	205	27.5	205		350	61
62	1ST FL NURSING STATION SOCKETS/LIGHTING/BUILT-IN KITCHEN CABINETS/BATHROOM TILEWORK,PIPING,DRYWALL/LIBRARY DUCTWORK & VENTS/WALLPAPER/								62
63	& SEAL WINDOWS/1ST FL BATHROOM DEMOLITION-NEW DRYWALL/SOFFITS/CONCRETE/PLUMBING/ELECTRIC/TILING/FIXTURES/PRIME/PAINT/FLOORING/THERAPY								63
64	ROOM FLOORING	2012	50,751	846	27.5	846		846	64
65	A/C FOR DINING ROOM	2012	3,120	52	27.5	52		52	65
66									66
67									67
68	ADJUST TO STRAIGHT LINE			(16,783)			16,783		68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,611,323	$ 61,694		$ 61,694	$	$ 1,520,599	70

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 51,505	$ 5,264	$ 5,264	$	8-10 YRS	$ 24,716	71
72	Current Year Purchases	7,329	469	469		5-10 YRS	469	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 58,834	$ 5,733	$ 5,733	$		$ 25,185	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	$	$	$	4 YRS	$ 58,079	76
77	ACTIVITIES,MAINT,									77
78	& PURCHASING,ETC									78
79										79
80	TOTALS			$ 58,079	$	$	$		$ 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)	$ 2,808,745	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 67,427	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 67,427	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,603,863	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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 103,242	$		$ 103,242	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			14,074			14,074	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			155,133			155,133	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				95,966		95,966	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					9,856		9,856	13
14	TOTAL			$		$ 272,449	$ 105,822		$ 378,271	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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 201,946	$ 1,029,241	1
2	Cash-Patient Deposits	28,331	35,607	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,656,376	1,661,222	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,328	52,328	6
7	Other Prepaid Expenses	20,869	23,915	7
8	Accounts Receivable (owners or related parties)		818,111	8
9	Other(specify): DUE TO DOBSON PLAZA INC	333,891		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,293,741	$ 3,620,424	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		561,044	15
16	Equipment, at Historical Cost		116,913	16
17	Accumulated Depreciation (book methods)		(1,724,984)	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	288,869	288,869	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 288,869	$ 1,404,632	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,582,610	$ 5,025,056	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 218,623	$ 224,657	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,331	35,607	28
29	Short-Term Notes Payable	200,000	521,000	29
30	Accrued Salaries Payable	75,136	75,136	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,703	7,703	31
32	Accrued Real Estate Taxes(Sch.IX-B)		197,790	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	215,578	215,578	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 745,371	$ 1,277,471	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,613,954	40
41	Bonds Payable			41
42	Deferred Compensation	915,948	915,948	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 915,948	$ 4,529,902	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,661,319	$ 5,807,373	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 921,291	$ (782,317)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,582,610	$ 5,025,056	48

*(See instructions.)

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 239,752	1	
2	Restatements (describe):		2	
3	ROUNDING	2	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 239,754	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	681,537	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 681,537	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)**	$ 921,291	24	*

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,242,443	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,242,443	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,760	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 179,760	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,962	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,962	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	74	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 74	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)**	$ 6,425,239	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	627,766	31
32	Health Care	2,234,359	32
33	General Administration	1,013,693	33
	B. Capital Expense		
34	Ownership	1,152,418	34
	C. Ancillary Expense		
35	Special Cost Centers	378,271	35
36	Provider Participation Fee	337,195	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,743,702	40
41	**Income before Income Taxes (line 30 minus line 40)****	681,537	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 681,537	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,372,198	44
45	Private Pay - Net Inpatient Revenue	2,337,497	45
46	Medicare - Net Inpatient Revenue	1,434,667	46
47	Other-(specify) VA,HOSPICE, ETC	98,081	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,242,443	49

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

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

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

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

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1,963	2,246	$ 98,274	$ 43.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,402	23,951	773,533	32.30	3
4	Licensed Practical Nurses	5,609	6,172	148,851	24.12	4
5	CNAs & Orderlies	53,767	60,037	696,831	11.61	5
6	CNA Trainees					6
7	Licensed Therapist	647	691	36,667	53.06	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,156	2,476	44,078	17.80	9
10	Activity Assistants	4,043	4,230	56,665	13.40	10
11	Social Service Workers	1,545	1,667	34,062	20.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,893	3,227	35,942	11.14	14
15	Cook Helpers/Assistants	7,582	8,478	75,889	8.95	15
16	Dishwashers					16
17	Maintenance Workers	3,994	4,650	52,267	11.24	17
18	Housekeepers	4,137	4,684	44,270	9.45	18
19	Laundry	2,854	3,121	27,415	8.78	19
20	Administrator	2,091	2,091	183,989	87.99	20
21	Assistant Administrator	194	313	10,544	33.69	21
22	Other Administrative	1,298	1,298	64,750	49.88	22
23	Office Manager					23
24	Clerical	4,642	5,189	98,486	18.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,519	1,601	53,846	33.63	31
32	Other Health C: MDS/QA/ADMIT'	4,921	5,004	158,095	31.59	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,257	141,126	$ 2,694,454 *	$ 19.09	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	$ 61,043	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	4,512	10-3	37
38	Nurse Consultant	T	6,535	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	4,380	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)		$ 92,310		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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLOTTE KOHN	ADMINISTRATOR	**	$ 183,989
PAM SEEFURTH	ASST ADMIN		10,544
BARAK KOHN	OTHER ADMIN	**	41,193
REBECCA KOHN	OTHER ADMIN	**	23,557
** BY ATTRIBUTION 100% KOHN FAMILY OWNED			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 259,283

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
ALPHA DATA	DATA PROCESSING	$ 5,351
VISIONSHARE	DATA PROCESSING	720
KRUPNICK BOKOR	ACCOUNTANT	19,350
MYRON TUSHBAI	ACCOUNTANT	2,375
RIEFF SCHRAMM KANTER	REAL EST TAX FILING FEES	450
RICHARD PEELO	MEDICARE COST REPORT	3,250
MUCH SHELIST	LEGAL-DISALLOWED see 5A	4,204
KEITH GOLDBERG	LEGAL-DISALLOWED see 5A	900
SYLVESTER LAW FIRM	LEGAL-DISALLOWED see 5A	1,022
ADVANTAGE BENEFITS	501K ADMINISTRATION	1,854
PERSONNEL PLANNERS	UC CONSULTANT	600
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 40,076

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,483
Unemployment Compensation Insurance	14,710
FICA Taxes	200,348
Employee Health Insurance	195,795
Employee Meals	10,468
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	600
EMPLOYEE PHYSICAL EXAMS	355
PENSION/PROFIT SHARING PLANS	(5,971)
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 460,788

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	$
Advertising: Employee Recruitment	3,150
Health Care Worker Background Check	570
(Indicate # of checks performed 13)	
Patient Background Checks 44	440
TRUST/FRANCHISE/CONTRIB/ETC	655
MARKETING/ADV/PROMO	35,871
LICENSES/DUES/SUBSCRIPTIONS	6,906
TRUST/FRANCHISE/CONTRIB/ETC	(655)
Less: Public Relations Expense	(0)
Non-allowable advertising	(18,789)
Yellow page advertising	(17,082)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,066

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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 # 0051508 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. $ **32,391** 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. $ **337,195**
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. $ **10,468** 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.