FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051508

Facility Name: DOBSON PLAZA

Address: 120 DODGE AVENUE (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 01/01/2015 to 12/31/2015 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) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			3,003	3,003	8
9	SNF/PED					9
10	ICF	18,256	9,502	941	28,699	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,256	9,502	3,944	31,702	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.54%

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 3,003

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	102,454	17,038	53,353	172,845		172,845		172,845			1
2	Food Purchase		160,873		160,873	(11,388)	149,485	(703)	148,782			2
3	Housekeeping	64,670	25,402		90,072		90,072		90,072			3
4	Laundry	36,335	10,523	2,638	49,496		49,496		49,496			4
5	Heat and Other Utilities			92,790	92,790		92,790		92,790			5
6	Maintenance	53,643	10,828	51,798	116,269		116,269		116,269			6
7	Other (specify):*			7,746	7,746		7,746		7,746			7
8	**TOTAL General Services**	257,102	224,664	208,325	690,091	(11,388)	678,703	(703)	678,000			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	2,014,055	95,338	8,906	2,118,299		2,118,299		2,118,299			10
10a	Therapy		5,156	42,055	47,211		47,211		47,211			10a
11	Activities	97,610	18,038	1,000	116,648		116,648		116,648			11
12	Social Services	27,100		3,840	30,940		30,940		30,940			12
13	CNA Training											13
14	Program Transportation			883	883		883		883			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,138,765	118,532	67,684	2,324,981		2,324,981		2,324,981			16
	C. General Administration											
17	Administrative	269,605		207,500	477,105		477,105	(280,994)	196,111			17
18	Directors Fees											18
19	Professional Services			80,515	80,515		80,515	(350)	80,165			19
20	Dues, Fees, Subscriptions & Promotions			60,371	60,371		60,371	(50,345)	10,026			20
21	Clerical & General Office Expenses	103,149	14,313	38,170	155,632		155,632	(14,349)	141,283			21
22	Employee Benefits & Payroll Taxes			499,478	499,478	11,388	510,866		510,866			22
23	Inservice Training & Education			684	684		684		684			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,653	4,653		4,653		4,653			25
26	Insurance-Prop.Liab.Malpractice			73,291	73,291		73,291		73,291			26
27	Other (specify):*											27
28	**TOTAL General Administration**	372,754	14,313	964,662	1,351,729	11,388	1,363,117	(346,038)	1,017,079			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,768,621	357,509	1,240,671	4,366,801		4,366,801	(346,741)	4,020,060			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: 01/01/2015** **Ending: 12/31/2015**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	50,170	
	REPAIRS & MAINTENANCE		0	
	OUTSIDE SERVICES-DIETARY		3,183	53,353
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,638	
				2,638
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		15,165	
	ELECTRICITY		39,673	
	WATER		34,975	
	CABLE TV - LOBBY		2,977	
				92,790
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,199	
	PAINTING & DECORATING		1,231	
	BUILDING REPAIRS		3,152	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		23,539	
	ELEVATOR MAINTENANCE & REPAIR		9,153	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,996	
	FIRE SERVICE		6,528	
				51,798
7	**OTHER**			
	SCAVENGER		7,746	
	SECURITY SERVICE		0	

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	403	
	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	4,696	
	PHARMACY CONSULTANT	XVIII B 39-2	592	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	3,215	
				8,906
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		23,169	
	SPEECH THERAPY SERVICES		5,141	
	OCCUPATIONAL THERAPY SERVICES		13,745	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				42,055
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	CLERGY		1,000	1,000
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,840	

				7,746
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	11,000	11,000

				3,840
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DOBSON PLAZA **#0051508** **Report Period Beginning: 01/01/2015** **Ending: 12/31/2015**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		883	
				883
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	207,500	207,500
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	26,241	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	54,274	
				80,515
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	MARKETING & OTHER NON-PATIENT RELATEI	VI 19 XIX F	5,279	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	27,114	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	95	
	LICENSES & PERMITS	XIX F	9,011	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	17,047	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	405	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	850	
	PATIENT BACKGROUND CHECKS	XIX F	70	
				60,371
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		8,884	
	OUTSIDE CLERICAL SERVICES		3,175	
	PENALTIES / OVERDRAFT CHARGES	VI 18	14,492	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		11,619	

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	207,121	
	UNEMPLOYMENT COMPENSATION	XIX D	9,086	
	WORKERS COMPENSATION INSURANC	XIX D	40,375	
	HOSPITALIZATION INSURANCE	XIX D	246,533	
	EMPLOYEE BENEFITS - OTHER	XIX D	736	
	EMPLOYEE PHYSICAL EXAMS	XIX D	416	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	501 PLAN - CASH VALUE ADJ	XIX D	(4,789)	
				499,478
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		684	
				684
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,653	
				4,653
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		73,291	
				73,291
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **1,240,671**

MESSENGER SERVICE	0	
		38,170

10026

DOBSON PLAZA
SCHEDULES
12/31/2015

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

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

TOTAL FOOD PURCHASE	160,873
LESS SALES TAX	(703)
NET FOOD	160,170
TOTAL PATIENT CENSUS	31,702
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	95,106
ADD # EMPLOYEE MEALS/DAY	20
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	7,300
PATIENT MEALS	95,106
ADD EMPLOYEE MEALS	7,300
TOTAL MEALS/YEAR	102,406
NET FOOD	160,170
DIVIDE TOTAL MEALS/YEAR	102,406
COST PER MEAL	1.56
TIMES EMPLOYEE MEALS	7,300
EMPLOYEE MEAL RECLASSIFICATION	**11,388**

Facility Name & ID Number DOBSON PLAZA #0051508 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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							66,720	66,720			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							105,188	105,188			32
33	Real Estate Taxes			234,336	234,336		234,336		234,336			33
34	Rent-Facility & Grounds			1,020,000	1,020,000		1,020,000	(1,020,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			5,368	5,368		5,368		5,368			36
37	**TOTAL Ownership**			1,259,704	1,259,704		1,259,704	(848,092)	411,612			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,019	3,019		3,019		3,019			38
39	Ancillary Service Centers		93,323	366,242	459,565		459,565		459,565			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,376	229,376		229,376		229,376			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		93,323	598,637	691,960		691,960		691,960			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,768,621	450,832	3,099,012	6,318,465		6,318,465	(1,194,833)	5,123,632			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: 01/01/2015 Ending: 12/31/2015

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				9
10	Interest and Other Investment Income	(843)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary	(207,500)	17		12
13	Sales Tax	(703)	2		13
14	Non-Care Related Interest				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	(14,492)	21		18
19	Entertainment				19
20	Contributions	(500)	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	(32,393)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(17,047)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(73,844)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (347,727)		$	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)	(847,106)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (847,106)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,194,833)		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: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DISALLOWED EXCESS OWNER SALARY	$ (73,494)	17	1
2	DISALLOWED LEGAL-CORPORATE MATTERS	(350)	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**	(73,844)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA # 0051508 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	(703)	0	0	0	0	0	0	0	0	0	0	(703)	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**	(703)	0	0	0	0	0	0	0	0	0	0	(703)	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	(280,994)	0	0	0	0	0	0	0	0	0	0	(280,994)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(350)	0	0	0	0	0	0	0	0	0	0	(350)	19
20	Fees, Subscriptions & Promotions	(50,345)	0	0	0	0	0	0	0	0	0	0	(50,345)	20
21	Clerical & General Office Expenses	(14,492)	143	0	0	0	0	0	0	0	0	0	(14,349)	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**	(346,181)	143	0	0	0	0	0	0	0	0	0	(346,038)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(346,884)	143	0	0	0	0	0	0	0	0	0	(346,741)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA # 0051508 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	66,720	0	0	0	0	0	0	0	0	0	66,720	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(843)	106,031	0	0	0	0	0	0	0	0	0	105,188	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,020,000)	0	0	0	0	0	0	0	0	0	(1,020,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(843)	(847,249)	0	0	0	0	0	0	0	0	0	(848,092)	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)**	(347,727)	(847,106)	0	0	0	0	0	0	0	0	0	(1,194,833)	45

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 1,020,000	DOBSON PLAZA INC		$	$ (1,020,000)	1
2	V	30	SL DEPRECIATION		" "		66,720	66,720	2
3	V	32	INTEREST		" "		106,031	106,031	3
4	V	21	OFFICE EXPENSE		" "		143	143	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,020,000			$ 172,894	$ * (847,106)	14

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	90,000	33	55.00	SALARY	$ 110,000	17-1	1
2	BARAK KOHN	BUILDING ADMIN	SUPERVISION	0.00	11,153	18	60.00	SALARY	28,577	17-1	2
3	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	52,533	6	50.00	SALARY	55,533	17-1	3
4											4
5											5
6											6
7											7
8											8
9	BY ATTRIBUTION, 100% KOHN FAMILY OWNED										9
10											10
11	CERTAIN AMOUNTS ON THIS PAGE HAVE BEEN ADJUSTED TO REFLECT EXPECTED IL DEPT OF HFS ALLOWABLE LIMITATIONS										11
12											12
13								TOTAL	$ 194,110		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: 01/01/2015 Ending: 2/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	3,044,359	12/05/19	3.2500	105,881	2
3	MB FINANCIAL		X	LINE OF CREDIT	DEMAND					PRIME+	150	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$32,880.35		$ 5,500,000	$ 3,044,359			$ 106,031	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,500,000	$ 3,044,359			$ 106,031	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: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	225,950	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.)	$	228,996	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,046	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	231,290	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.	$	234,336	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	194,850	8
	2011	195,834	9
	2012	205,168	10
	2013	223,708	11
	2014	228,996	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 2014 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.**

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOBSON PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051508

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-113-043-0000	NURSING HOME	$ 228,342.56	$ 228,342.56
2.	10-25-220-015-0000	NURSING HOME	$ 653.17	$ 653.17
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 228,995.73	$ 228,995.73

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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)	660,697	6
7	2			1971	11,147		8-12			11,147	7
8	4			1987	64,011		30	1,067	1,067	14,938	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			5,650	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			42,241	18
19	HEATING, VENTILATION, & A/C			1988	48,620		20			48,620	19
20	PLUMBING COMPOSITE			1988	63,062		25			63,062	20
21	ELECTRICAL WIRING			1988	115,484		20			115,484	21
22	BRICK-ENCLOSED GENERATOR			1989	1,375		25	27	27	1,375	22
23	FENCE - GENERATOR			1989	480		15			480	23
24	CATCH BASIN			1989	5,000		10			5,000	24
25	REMODELLING OF ANCILLARY AREAS			1997	534,985	16,180	40	13,374	(2,806)	254,106	25
26	CANOPY SIGN			1999	8,000	205	39	205		3,357	26
27	ELEVATOR REPAIR			1999	1,990	51	39	51		827	27
28	FIRE DAMPERS / AIR INTAKES			2000	10,515	382	27.5	382		5,969	28
29	ELEVATOR UPGRADE / AIR INTAKES			2000	28,259	1,028	27.5	1,028		15,549	29
30	ELEVATOR UPGRADE			2001	18,977	690	27.5	690		10,206	30
31	CARPETING			2001	25,597		10			25,597	31
32	HEAT EXCHANGER / FIRE SUPPRESSION SYSTEM			2003	11,572	421	27.5	421		5,359	32
33	HYDRAULIC ELEVATOR PUMP			2006	10,772	392	27.5	392		3,838	33
34	BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER			2006	29,463	1,071	27.5	1,071		10,281	34
35	NURSG STN/BATHRMS/PLUMBG/FLOORING/ROOF FASCIA			2007	53,627	1,950	27.5	1,950		16,655	35
36	BEAUTY SHOP DRYWALL,CABINETRY,PLUMBING,TILE			2007	7,287	265	27.5	265		2,109	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: 01/01/2015 Ending: 12/31/2015

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	$	$ 2,413	37
38	PT,AAD,DAYRMS-DRYWALL,FLOORING,STUDS,JOIST	2008	19,380	705	27.5	705		5,493	38
39	BATHRMS:TILE,FLOOR,DRYWALL,PAINT,PAPER,FIXTURE	2008	15,425	561	27.5	561		4,285	39
40	REPIPE KITCHEN WATER LINES	2008	2,065	75	27.5	75		580	40
41	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	109	27.5	109		824	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		10,069	43
44	ROOF	2008	18,500	673	27.5	673		4,795	44
45	CARPETING	2008	11,259		10	1,126	1,126	9,011	45
46	DRIVEWAY/PARKINGLOT	2008	18,807	1,254	15	1,254		9,404	46
47	THERAPY ROOM WALL/SHELVING/CARPENTRY/6 DOORS	2009	5,530	201	27.5	201		1,390	47
48	ROOF/5-TON AC CONDENSER/WINDOWS	2009	12,325	443	27.5	448	5	2,994	48
49	SECURITY SYSTEM/CABLES/WANDERGUARD WIRING	2009	5,671	206	27.5	206		1,372	49
50	CARPENTRY/RECESSED LIGHTING/WIRING 28 OUTLETS	2009	7,975	290	27.5	290		1,825	50
51	SUMP PUMP MOTOR & PIPELINES	2009	3,700	135	27.5	135		851	51
52	CERAMIC FLOOR/CARPENTRY/CLOSET/INTERCOM/CABL	2009	2,919	107	27.5	108	1	653	52
53	CARPETING/WINDOW TREATMENTS/WALLPAPER	2009	13,299		10	1,330	1,330	8,645	53
54	OUTLETS/CABLE/WALL MOUNTS	2010	8,730	317	27.5	317		1,836	54
55	NURSING STATION BUILT-INS/DRYWALL/SINK/COUNTER	2010	5,911	215	27.5	215		1,263	55
56	DELAYED ELEVATOR EGRESS LOCKS	2010	3,868	141	27.5	141		793	56
57	WALLPAPER/CARPETING/COVE BASE/BASEBOARDS	2010	12,741	368	10	1,274	906	7,007	57
58	SUMP PUMP	2010	7,719	281	27.5	281		1,464	58
59	WEIL PUMP 2224	2011	5,119		10	512	512	2,304	59
60	2ND FL NURSING STATION / CARPENTRY / BUILT-INS / CLOSET / RAILS / VINYL FLOORING:								60
61		2011	5,647	205	27.5	205		965	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	1,845	27.5	1,845		6,381	64
65	A/C FOR DINING ROOM	2012	3,120	113	27.5	113		391	65
66	WIRING	2014	5,597	204	27.5	204		331	66
67	SECURITY SYSTEM UPGRADES	2015	3,100	1,860	5	181	(1,679)	181	67
68	ELEVATOR-RETRACTABLE LADDER & WIRING	2015	4,026	43	27.5	43		43	68
69	2ND FL CORRIDOR & DAYROOM FLOORING	2015	17,697	27	27.5	27		27	69
70	TOTAL (lines 4 thru 69)		$ 2,641,743	$ 72,829		$ 58,487	$ (14,342)	$ 1,701,961	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: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,641,743	$ 72,829		$ 58,487	$ (14,342)	$ 1,701,961	1
2									2
3									3
4	ADJUST TO STRAIGHT LINE			(14,342)			14,342		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	TOTAL (lines 1 thru 33)		$ 2,641,743	$ 58,487		$ 58,487	$	$ 1,701,961	34

**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: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 70,606	$ 8,233	$ 8,233	$	8-10 YRS	$ 37,159	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 70,606	$ 8,233	$ 8,233	$		$ 37,159	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)	$ 2,850,937	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 66,720	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 66,720	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)	$ 1,797,199	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: 01/01/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 0 Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	$		$ 112,748	$		$ 112,748	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			47,504			47,504	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			205,990			205,990	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				86,392		86,392	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					6,931		6,931	13
14	TOTAL			$		$ 366,242	$ 93,323		$ 459,565	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 **#** 0051508 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2015 **(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	$ 1,170,107	$ 1,466,384	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,513,040	1,513,040	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		508,037	5
6	Prepaid Insurance	53,224	53,224	6
7	Other Prepaid Expenses		1,162	7
8	Accounts Receivable (owners or related parties)		874,399	8
9	Other(specify): DUE TO DOBSON PLAZA INC	807,683		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,544,054	$ 4,416,246	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		591,464	15
16	Equipment, at Historical Cost		128,684	16
17	Accumulated Depreciation (book methods)		(1,959,911)	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	304,755	304,755	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 304,755	$ 1,227,782	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,848,809	$ 5,644,028	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 196,261	$ 200,958	26
27	Officer's Accounts Payable	207,500	207,500	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	92,966	92,966	29
30	Accrued Salaries Payable	102,603	102,603	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,759	9,759	31
32	Accrued Real Estate Taxes(Sch.IX-B)		231,290	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MORTGAGE PAYABLE-CURRENT		300,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 609,089	$ 1,145,076	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,744,359	40
41	Bonds Payable			41
42	Deferred Compensation	1,039,201	1,039,201	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,039,201	$ 3,783,560	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,648,290	$ 4,928,636	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,200,519	$ 715,392	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,848,809	$ 5,644,028	48

***(See instructions.)**

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,868,850	1
2	Restatements (describe):		2
3			3
4	ROUNDING	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,868,852	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	946,667	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	(615,000)	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)**	$ 331,667	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)**	$ 2,200,519	24 *

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 6,868,115	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,868,115	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	396,446	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 396,446	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	4,519	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**	$ 4,519	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	843	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 843	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)**	$ 7,269,923	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	690,091	31
32	Health Care	2,324,981	32
33	General Administration	1,351,729	33
	B. Capital Expense		
34	Ownership	1,259,704	34
	C. Ancillary Expense		
35	Special Cost Centers	462,584	35
36	Provider Participation Fee	229,376	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,318,465	40
41	**Income before Income Taxes (line 30 minus line 40)****	951,458	41
42	**Income Taxes**	(4,791)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 946,667	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,919,224	44
45	Private Pay - Net Inpatient Revenue	2,079,294	45
46	Medicare - Net Inpatient Revenue	1,701,724	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	167,873	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,868,115	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: 01/01/2015 Ending: 12/31/2015

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	1,791	2,128	$ 100,825	$ 47.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,109	23,651	766,070	32.39	3
4	Licensed Practical Nurses	5,704	6,422	162,525	25.31	4
5	CNAs & Orderlies	54,401	60,847	761,038	12.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,737	2,047	35,887	17.53	9
10	Activity Assistants	4,677	4,755	61,723	12.98	10
11	Social Service Workers	1,086	1,218	27,100	22.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,266	2,623	30,366	11.58	14
15	Cook Helpers/Assistants	7,039	7,703	72,088	9.36	15
16	Dishwashers					16
17	Maintenance Workers	3,897	4,532	53,643	11.84	17
18	Housekeepers	5,606	6,273	64,670	10.31	18
19	Laundry	3,433	3,801	36,335	9.56	19
20	Administrator	2,086	2,086	185,495	88.92	20
21	Assistant Administrator	1,003	1,003	28,577	28.49	21
22	Other Administrative	521	521	55,533	106.59	22
23	Office Manager					23
24	Clerical	4,849	5,203	103,149	19.82	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	1,885	2,134	71,807	33.65	31
32	Other Health Ca ADMIT/QA/MDS	4,169	4,169	151,790	36.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,259	141,116	$ 2,768,621 *	$ 19.62	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	$ 50,170	1-3	35
36	Medical Director	O	11,000	9-3	36
37	Medical Records Consultant	N	4,696	10-3	37
38	Nurse Consultant	T	3,215	10-3	38
39	Pharmacist Consultant	H	592	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 69,673		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	27	403	10-3	52
53	TOTAL (lines 50 - 52)	27	$ 403		53

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLOTTE KOHN	ADMINISTRATOR	**	$ 185,495
BARAK KOHN	ASST ADMIN	**	28,577
REBECCA KOHN	OTHER ADMIN	**	55,533
** BY ATTRIBUTION 100% KOHN FAMILY OWNED			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 269,605

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SERVICES	DATA PROCESSING	$ 5,165
MDI ACHIEVE	DATA PROCESSING	21,076
MYRON TUSHBAI	ACCOUNTING	8,060
KBKB LLC	ACCOUNTING	22,600
RICHARD PEELO	MEDICARE COST REPORT	3,250
PERSONNEL PLANNING	UNEMPLOYMENT CONSULT	600
ADVANTAGE BENEFITS	501A CONSULTANT	2,171
REIFF SCHRAMM KANTER	REAL ESTATE TAX LEGAL	695
AGNES GROSSMAN	LEGAL	521
STONE POGRUND & KOREY	LEGAL	14,822
MUCH SHELIST	LEGAL	1,555
SEE ATTACHED LEGAL SCHEDULE		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 80,515

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,375
Unemployment Compensation Insurance	9,086
FICA Taxes	207,121
Employee Health Insurance	246,533
Employee Meals	11,388
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	736
EMPLOYEE PHYSICAL EXAMS	416
PENSION/PROFIT SHARING PLANS (CVA)	(4,789)
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 510,866

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	0
Health Care Worker Background Check	850
(Indicate # of checks performed 32)	
Patient Background Checks 7	70
TRUST/FRANCHISE/CONTRIB/ETC	905
MARKETING/ADV/PROMO	49,440
LICENSES/DUES/SUBSCRIPTIONS	7,116
TRUST/FRANCHISE/CONTRIB/ETC	(905)
Less: Public Relations Expense	(5,279)
Non-allowable advertising	(27,114)
Yellow page advertising	(17,047)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,026

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.

DOBSON PLAZA
LEGAL FEES SCHEDULE
12/31/2015

DATE	FIRM	INVOICE #	PURPOSE	COST	TOTAL COST
2.15	RIEFF SCHRAMM KANTER GUTTMAN	JS3506hk	PROJECTED 2014 REAL ESTATE TAX SAVINGS	470.00	
3.15	RIEFF SCHRAMM KANTER GUTTMAN	30915	REAL ESTATE TAX ABATEMENT-FILING FEE	225.00	
					695.00
8.15	AGNES GROSSMAN		GUARDIAN AD LITEM FEES	300.00	
10.15	AGNES GROSSMAN		GUARDIAN AD LITEM FEES	221.25	
					521.25
1.15	STONE POGRUND KOREY	49807	LEGAL GUARDIANSHIP	300.00	
4.15	STONE POGRUND KOREY	52654	LEGAL GUARDIANSHIP	350.00	
6.15	STONE POGRUND KOREY	53561	LEGAL GUARDIANSHIP	562.50	
6.15	STONE POGRUND KOREY	54147	LEGAL GUARDIANSHIP	750.00	
7.15	STONE POGRUND KOREY	54963	LEGAL GUARDIANSHIP	1,494.50	
9.15	STONE POGRUND KOREY	55394	LEGAL GUARDIANSHIP	1,924.91	
10.15	STONE POGRUND KOREY	58102	LEGAL GUARDIANSHIP	4,885.74	
10.15	STONE POGRUND KOREY	59785	LEGAL GUARDIANSHIP	1,915.04	
11.15	STONE POGRUND KOREY	60798	LEGAL GUARDIANSHIP	1,450.00	
12.15	STONE POGRUND KOREY	62699	LEGAL GUARDIANSHIP	1,189.68	
					14,822.37
2.15	MUCH SHELIST	424466	MEETING W/IDPH ATTY & JUDGE	73.00	
3.15	MUCH SHELIST	426183	SETTLEMENT PROPOSAL - IDPH	511.00	
5.15	MUCH SHELIST	428949	PHONE CONFERENCE W/IDPH ATTY & JUDGE	328.50	
7.15	MUCH SHELIST	432032	PHONE CONF W/A.SCHWARTZ & JUDGE	146.00	
8.15	MUCH SHELIST	433452	PHONE CONF RE: SETTLEMENT AGREEMENT	146.00	
	DISALLOWED LEGAL TO PG 5A:				
8.15	**MUCH SHELIST**	**433930**	**ANNUAL FILING FEE**	**350.00**	
					1,554.50

TOTAL	**17,593.12**

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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:** 01/01/2015 **Ending:** 12/31/2015

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. $ **17,567** 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. $ **229,376**
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. $ **11,388** 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 out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.