FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 01/01/2016 to 12/31/2016 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: 01/01/2016 Ending: 12/31/2016

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			2,808	2,808	8
9	SNF/PED					9
10	ICF	19,715	9,299	732	29,746	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,715	9,299	3,540	32,554	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.70%

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 2,808

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	161,688	9,111	16,760	187,559		187,559	0	187,559			1
2	Food Purchase		160,126		160,126	(11,096)	149,030	(684)	148,346			2
3	Housekeeping	59,232	40,801	0	100,033		100,033	0	100,033			3
4	Laundry	25,161	12,101	5,432	42,694	0	42,694	0	42,694			4
5	Heat and Other Utilities			82,792	82,792		82,792	0	82,792			5
6	Maintenance	49,990	9,659	44,170	103,819		103,819	0	103,819			6
7	Other (specify):*			7,953	7,953		7,953	0	7,953			7
8	TOTAL General Services	296,071	231,798	157,107	684,976	(11,096)	673,880	(684)	673,196			8
	B. Health Care and Programs											
9	Medical Director	0		12,000	12,000		12,000	0	12,000			9
10	Nursing and Medical Records	2,065,562	102,557	8,686	2,176,805		2,176,805	0	2,176,805			10
10a	Therapy	0	5,102	144,053	149,155		149,155	0	149,155			10a
11	Activities	89,731	20,565	0	110,296		110,296	0	110,296			11
12	Social Services	28,627		3,840	32,467		32,467	0	32,467			12
13	CNA Training			0	0		0	0	0			13
14	Program Transportation			305	305		305	0	305			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	2,183,920	128,224	168,884	2,481,028	0	2,481,028	0	2,481,028			16
	C. General Administration											
17	Administrative	273,309		218,646	491,955		491,955	(294,635)	197,320			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			74,922	74,922		74,922	1,500	76,422			19
20	Dues, Fees, Subscriptions & Promotions			54,939	54,939		54,939	(41,226)	13,713			20
21	Clerical & General Office Expenses	102,339	15,560	28,206	146,105		146,105	(5,886)	140,219			21
22	Employee Benefits & Payroll Taxes			469,861	469,861	11,096	480,957	0	480,957			22
23	Inservice Training & Education			1,146	1,146		1,146	0	1,146			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			4,414	4,414		4,414	0	4,414			25
26	Insurance-Prop.Liab.Malpractice			81,390	81,390		81,390	0	81,390			26
27	Other (specify):*			0	0		0	0	0			27
28	TOTAL General Administration	375,648	15,560	933,524	1,324,732	11,096	1,335,828	(340,247)	995,581			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,855,639	375,582	1,259,515	4,490,736	0	4,490,736	(340,931)	4,149,805			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: 01/01/2016** **Ending: 12/31/2016**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	16,760	
	REPAIRS & MAINTENANCE		0	
				16,760
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,432	
				5,432
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		13,642	
	ELECTRICITY		35,145	
	WATER		28,597	
	CABLE TV - LOBBY		5,408	
				82,792
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,036	
	PAINTING & DECORATING		806	
	BUILDING REPAIRS		2,345	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		12,547	
	ELEVATOR MAINTENANCE & REPAIR		6,116	
	OUTSIDE LABOR		1,322	
	EXTERMINATING SERVICE		2,796	
	FIRE SERVICE		16,202	
				44,170
7	**OTHER**			
	SCAVENGER		7,953	
	SECURITY SERVICE		0	
				7,953
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	5,000	
	PHARMACY CONSULTANT	XVIII B 39-2	3,686	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				8,686
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		81,591	
	SPEECH THERAPY SERVICES		924	
	OCCUPATIONAL THERAPY SERVICES		60,833	
	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	705	
				144,053
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	CLERGY			0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	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: 01/01/2016** **Ending: 12/31/2016**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		305	
				305
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	218,646	218,646
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	25,970	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	48,952	
				74,922
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	1,912	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	23,512	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	0	
	LICENSES & PERMITS	XIX F	10,718	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	17,714	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,003	
	PATIENT BACKGROUND CHECKS	XIX F	80	
				54,939
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		4,788	
	OUTSIDE CLERICAL SERVICES		5,293	
	PENALTIES / OVERDRAFT CHARGES	VI 18	5,889	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,236	
	MESSENGER SERVICE		0	
				28,206

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	200,292	
	UNEMPLOYMENT COMPENSATION	XIX D	8,033	
	WORKERS COMPENSATION INSURANC	XIX D	41,003	
	HOSPITALIZATION INSURANCE	XIX D	195,947	
	EMPLOYEE BENEFITS - OTHER	XIX D	28,675	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	501 PLAN - CASH VALUE ADJ	XIX D	(4,089)	
				469,861
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,146	
				1,146
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,414	
				4,414
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		81,390	
				81,390
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **1,259,515**

DOBSON PLAZA
SCHEDULES
12/31/2016

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

TOTAL FOOD PURCHASE	160,126
LESS SALES TAX	(684)
NET FOOD	159,442
TOTAL PATIENT CENSUS	32,554
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	97,662
ADD # EMPLOYEE MEALS/DAY	20
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	7,300
PATIENT MEALS	97,662
ADD EMPLOYEE MEALS	7,300
TOTAL MEALS/YEAR	104,962
NET FOOD	159,442
DIVIDE TOTAL MEALS/YEAR	104,962
COST PER MEAL	1.52
TIMES EMPLOYEE MEALS	7,300
EMPLOYEE MEAL RECLASSIFICATION	**11,096**

Facility Name & ID Number DOBSON PLAZA #0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			11,560	11,560		11,560	60,526	72,086			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			1,045	1,045		1,045	103,264	104,309			32
33	Real Estate Taxes			231,521	231,521		231,521	0	231,521			33
34	Rent-Facility & Grounds			1,020,000	1,020,000		1,020,000	(1,020,000)	0			34
35	Rent-Equipment & Vehicles			0	0		0	0	0			35
36	Other (specify):* STORAGE			4,470	4,470		4,470	0	4,470			36
37	**TOTAL Ownership**			1,268,596	1,268,596	0	1,268,596	(856,210)	412,386			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		108,570	287,684	396,254		396,254	0	396,254			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			231,888	231,888		231,888	0	231,888			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	108,570	519,572	628,142	0	628,142	0	628,142			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,855,639	484,152	3,047,683	6,387,474	0	6,387,474	(1,197,141)	5,190,333			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: 01/01/2016 Ending: 12/31/2016

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	(6,114)	30		9
10	Interest and Other Investment Income	(296)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary	(218,646)	17		12
13	Sales Tax	(684)	2		13
14	Non-Care Related Interest	(200)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,889)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,512)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(17,714)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(75,989)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (349,044)		$ 0	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)	(848,097)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (848,097)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,197,141)		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: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DISALLOWED EXCESS OWNER SALARY	$ (75,989)	17	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(75,989)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(684)	0	0	0	0	0	0	0	0	0	0	(684)	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	(684)	0	0	0	0	0	0	0	0	0	0	(684)	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	(294,635)	0	0	0	0	0	0	0	0	0	0	(294,635)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,500	0	0	0	0	0	0	0	0	0	1,500	19
20	Fees, Subscriptions & Promotions	(41,226)	0	0	0	0	0	0	0	0	0	0	(41,226)	20
21	Clerical & General Office Expenses	(5,889)	3	0	0	0	0	0	0	0	0	0	(5,886)	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	(341,750)	1,503	0	0	0	0	0	0	0	0	0	(340,247)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(342,434)	1,503	0	0	0	0	0	0	0	0	0	(340,931)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA # 0051508 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,114)	66,640	0	0	0	0	0	0	0	0	0	60,526	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(496)	103,760	0	0	0	0	0	0	0	0	0	103,264	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	(6,610)	(849,600)	0	0	0	0	0	0	0	0	0	(856,210)	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)	(349,044)	(848,097)	0	0	0	0	0	0	0	0	0	(1,197,141)	45

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		" "		66,640	66,640	2
3	V	32	INTEREST		" "		103,760	103,760	3
4	V	21	OFFICE EXPENSE		" "		3	3	4
5	V	19	ACCOUNTING FEES		" "		1,500	1,500	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			$ 171,903	$ * (848,097)	14

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	11,181	18	60.00	SALARY	28,654	17-1	2
3	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	52,666	6	50.00	SALARY	58,666	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	$ 197,320		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: 01/01/2016 Ending: 2/31/2016

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: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MB FINANCIAL		X	AUTO LOAN	$1,188.14	08/16/16	$ 66,057	$ 62,007	08/16/21	PRIME+	$ 845	1
2												2
3												3
4	RELATED PARTY - DOBSON PLAZA INC:											4
5	MB FINANCIAL		X	MORTGAGE	$32,880.35	12/16/04	5,500,000	2,748,943	12/05/19	0.0325	103,760	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$34,068.49		$ 5,566,057	$ 2,810,950			$ 104,605	9
	B. Non-Facility Related*											
10	LATE FEES										200	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 200	14
15	TOTALS (line 9+line14)						$ 5,566,057	$ 2,810,950			$ 104,805	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: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	231,290	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.)	$	231,211	2
3. Under or (over) accrual (line 2 minus line 1).	$	(79)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	231,600	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.	$	231,521	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	195,834	8
	2012	205,168	9
	2013	223,708	10
	2014	228,996	11
	2015	231,211	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL THE PAYMENT ON LINE 2 APPLIES TO THE 2015 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-113-043-0000	NURSING HOME	$ 659.46	$ 659.46
2.	10-25-220-015-0000	NURSING HOME	$ 230,551.40	$ 230,551.40
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 231,210.86	$ 231,210.86

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

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	18,167	1966	80,509	2
3	TOTALS	18,167		$ 80,509	3

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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)	683,965	6
7	2			1971	11,147		8-12			11,147	7
8	4	per audit -64011		1987	0		30				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	per audit -5,223		1986	0		20				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	per audit -12,335		1988	0		20				16
17	OUTSIDE SIGN			1988	2,473		12			2,473	17
18	SPRINKLER SYSTEM			1988	42,241		25			42,241	18
19	HEATING, VENTILATION, & A/C			1988	48,620		20			48,620	19
20	PLUMBING COMPOSITE			1988	63,062		25			63,062	20
21	ELECTRICAL WIRING			1988	115,484		20			115,484	21
22	BRICK-ENCLOSED GENERATOR			1989	1,375		25			1,375	22
23	FENCE - GENERATOR			1989	480		15			480	23
24	CATCH BASIN			1989	5,000		10			5,000	24
25	REMODELLING OF ANCILLARY AREAS	per audit -18,867		1997	516,118	16,180	40	13,374	(2,806)	267,480	25
26	CANOPY SIGN			1999	8,000	205	39	205		3,562	26
27	ELEVATOR REPAIR	per audit -1,990		1999	0	51	39		(51)		27
28	FIRE DAMPERS / AIR INTAKES			2000	10,515	382	27.5	382		6,351	28
29	ELEVATOR UPGRADE / AIR INTAKES	per audit -10,038		2000	18,221	1,028	27.5	1,028		16,577	29
30	ELEVATOR UPGRADE	per audit -756		2001	18,221	690	27.5	690		10,896	30
31	CARPETING	per audit -1,683		2001	23,914		10			23,914	31
32	HEAT EXCHANGER 8,650/ FIRE SUPPRESSION SYSTEM 2,922			2003	11,572	421	27.5	421		5,780	32
33	HYDRAULIC ELEVATOR PUMP			2006	10,772	392	27.5	392		4,230	33
34	BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER			2006	29,463	1,071	27.5	1,071		11,352	34
35	NURSG STN/BATHRMS/PLUMBG/FLOORING/ROOF FASCIA			2007	53,627	1,950	27.5	1,950		18,605	35
36	BEAUTY SHOP DRYWALL,CABINETRY,PLUMBING,TILE			2007	7,287	265	27.5	265		2,374	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: 01/01/2016 Ending: 12/31/2016

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	$	$ 2,719	37
38	PT,AAD,DAYRMS-DRYWALL,FLOORING,STUDS,JOIST	2008	19,380	705	27.5	705		6,198	38
39	BATHRMS:TILE,FLOOR,DRYWALL,PAINT,PAPER,FIXTURI	2008	15,425	561	27.5	561		4,846	39
40	REPIPE KITCHEN WATER LINES	2008	2,065	75	27.5	75		655	40
41	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	109	27.5	109		933	41
42	LOWER LEVEL BATHROOM PROJECT	2008	26,300	956	27.5	956		7,783	42
43	LOWER LEVEL NURSING STATION	2008	12,500	455	27.5	455		3,697	43
44	UPPER ROOF REPLACEMENT	2008	18,500	673	27.5	673		5,468	44
45	CARPETING	2008	11,259		10	1,126	1,126	10,137	45
46	DRIVEWAY/PARKINGLOT	2008	18,807	1,254	15	1,254		10,658	46
47	THERAPY ROOM WALL/SHELVING/CARPENTRY/6 DOORS	2009	5,530	201	27.5	201		1,591	47
48	2ND FLOOR ROOF/5-TON AC CONDENSER per audit -1,300	2009	11,025	443	27.5	443		3,437	48
49	SECURITY SYSTEM/CABLES/WANDERGUARD WIRING	2009	5,671	206	27.5	206		1,578	49
50	CARPENTRY/RECESSED LIGHTING/WIRING 28 OUTLETS	2009	7,975	290	27.5	290		2,115	50
51	SUMP PUMP MOTOR & PIPELINES	2009	3,700	135	27.5	135		986	51
52	CERAMIC FLOOR/CARPENTRY/CLOSET/INTERCOM/CABI	2009	2,919	107	27.5	108	1	761	52
53	CARPETING/WINDOW TREATMENTS/ per audit - 5,896	2009	7,403		10			7,403	53
54	OUTLETS/CABLE/WALL MOUNTS	2010	8,730	317	27.5	317		2,153	54
55	NURSING STATION BUILT-INS/DRYWALL per audit -900	2010	5,011	215	27.5	215		1,263	55
56	DELAYED ELEVATOR EGRESS LOCKS	2010	3,868	141	27.5	141		934	56
57	WALLPAPER/CARPETING/COVE BASE/BASEBOARDS	2010	12,741	368	10	1,274	906	8,281	57
58	SUMP PUMP	2010	7,719	281	27.5	281		1,745	58
59	WEIL PUMP 2224	2011	5,119	0	10	512	512	2,816	59
60	2ND FL NURSING STATION / CARPENTRY / BUILT-INS / CLOSET / RAILS / VINYL FLOORING:								60
61	per audit -2,632	2011	3,015	205	27.5	205		1,170	61
62	1ST FL NURSING STATION SOCKETS/LIGHTING/BUILT-IN KITCHEN CABINETS/BATHROOM TILEWORK,PIPING,DRYWALL/LIBRARY DU								62
63	& SEAL WINDOWS/1ST FL BATHROOM DEMOLITION-NEW DRYWALL/SOFFITS/CONCRETE/PLUMBING/ELECTRIC/TILING/FIXTURES/P								63
64	ROOM FLOORING per audit - 2,231	2012	48,520	1,845	27.5	1,845		8,226	64
65	A/C FOR DINING ROOM	2012	3,120	113	27.5	113		504	65
66	WIRING	2014	5,597	204	27.5	204		535	66
67	SECURITY SYSTEM UPGRADES	2015	3,100	496	5	620	124	801	67
68	ELEVATOR-RETRACTABLE LADDER & WIRING	2015	4,026	146	27.5	146		189	68
69	2ND FL CORRIDOR & DAYROOM FLOORING	2015	18,961	689	27.5	689		716	69
70	TOTAL (lines 4 thru 69)		$ 2,515,145	$ 72,230		$ 57,211	$ (15,019)	$ 1,722,709	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: 01/01/2016 Ending: 12/31/2016

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		$ 2,515,145	$ 72,230		$ 57,211	$ (15,019)	$ 1,722,709	1
2	HOT WATER TANK, INSTALLATION per audit -553	2016	10,253	264	27.5	264		264	2
3	1ST FLOOR CORRIDOR GLUE-DOWN CARPETING	2016	3,694	95	27.5	95		95	3
4	ELEVATOR MAIN CONTROL VALVE	2016	6,500	128	27.5	128		128	4
5									5
6									6
7	ADJUST TO STRAIGHT LINE			(15,019)			15,019		7
8									8
9									9
10	ADJUST TO BALANCE SHEET								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)		$ 2,535,592	$ 57,698		$ 57,698	$ 0	$ 1,723,196	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: 01/01/2016 Ending: 12/31/2016

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	$ 70,604	$ 8,184	$ 8,184	$ 0	8-10 YRS	$ 45,343	71
72	Current Year Purchases	12,127	758	758	0	8 YRS	758	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 82,731	$ 8,942	$ 8,942	$ 0		$ 46,101	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,	'17 ACURA MDX	2016	$ 65,357	$ 11,560	$ 5,446	$ (6,114)	5 YRS	$ 5,446	76
77	ACTIVITIES,MAINT,						0			77
78	& PURCHASING,ETC						0			78
79							0			79
80	TOTALS			$ 65,357	$ 11,560	$ 5,446	$ (6,114)		$ 5,446	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)	$ 2,764,189	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 78,200	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,086	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,114)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,774,743	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: 01/01/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 01/01/2016 Ending: 12/31/2016

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	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

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.

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	$		$ 95,116	$		$ 95,116	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			53,379			53,379	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			139,189			139,189	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				96,816		96,816	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					11,754		11,754	13
14	TOTAL			$		$ 287,684	$ 108,570		$ 396,254	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:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 130,711	$ 428,393	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,030,188	2,030,188	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		498,351	5
6	Prepaid Insurance	54,468	54,468	6
7	Other Prepaid Expenses	3,010	4,140	7
8	Accounts Receivable (owners or related parties)		889,995	8
9	Other(specify): DUE TO DOBSON PLAZA INC	793,144	0	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,011,521	$ 3,905,535	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		613,175	15
16	Equipment, at Historical Cost	65,357	206,167	16
17	Accumulated Depreciation (book methods)	(11,560)	(2,055,612)	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	308,844	308,844	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 362,641	$ 1,235,364	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,374,162	$ 5,140,899	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 221,623	$ 219,629	26
27	Officer's Accounts Payable	218,646	218,646	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	92,966	92,966	29
30	Accrued Salaries Payable	125,166	125,166	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,235	1,235	31
32	Accrued Real Estate Taxes(Sch.IX-B)		231,600	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)**	$ 659,636	$ 1,189,242	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	60,961	2,509,904	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	1,106,471	1,106,471	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,167,432	$ 3,616,375	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,827,068	$ 4,805,617	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,547,094	$ 335,282	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,374,162	$ 5,140,899	48

***(See instructions.)**

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,200,519	1
2	Restatements (describe):		2
3			3
4	ROUNDING	3	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,200,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,140,471	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	(1,793,899)	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)**	$ (653,428)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,547,094	24 *

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 7,235,357	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,235,357	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	311,696	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 311,696	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	2,479	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)**	$ 2,479	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	296	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 296	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)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,549,828	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	684,976	31
32	Health Care	2,481,028	32
33	General Administration	1,324,732	33
	B. Capital Expense		
34	Ownership	1,268,596	34
	C. Ancillary Expense		
35	Special Cost Centers	396,254	35
36	Provider Participation Fee	231,888	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,387,474	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,162,354	41
42	**Income Taxes**	(21,883)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,140,471	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,317,924	44
45	Private Pay - Net Inpatient Revenue	2,102,394	45
46	Medicare - Net Inpatient Revenue	1,632,144	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	182,895	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,235,357	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: 01/01/2016 Ending: 12/31/2016

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	1,825	2,072	$ 99,305	$ 47.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,003	25,858	822,160	31.80	3
4	Licensed Practical Nurses	4,394	5,009	128,895	25.73	4
5	CNAs & Orderlies	55,302	61,088	793,712	12.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,639	2,878	51,824	18.01	9
10	Activity Assistants	3,006	3,043	37,907	12.46	10
11	Social Service Workers	1,162	1,287	28,627	22.24	11
12	Dietician					12
13	Food Service Supervisor	1,143	1,152	35,898	31.16	13
14	Head Cook	1,145	1,159	17,868	15.42	14
15	Cook Helpers/Assistants	10,155	11,015	107,922	9.80	15
16	Dishwashers					16
17	Maintenance Workers	3,483	4,144	49,990	12.06	17
18	Housekeepers	4,715	5,311	59,232	11.15	18
19	Laundry	2,262	2,586	25,161	9.73	19
20	Administrator	2,091	2,091	185,989	88.95	20
21	Assistant Administrator	1,005	1,005	28,654	28.51	21
22	Other Administrative	522	522	58,666	112.39	22
23	Office Manager					23
24	Clerical	4,567	4,896	102,339	20.90	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	1,852	2,134	73,314	34.36	31
32	Other Health Care(specify)					32
33	Other(specify) ADMIT/QA	4,338	4,338	148,176	34.16	33
34	TOTAL (lines 1 - 33)	128,609	141,588	$ 2,855,639 *	$ 20.17	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	$ 16,760	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	5,000	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,686	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	705	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)		$ 41,991		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLOTTE KOHN	ADMINISTRATOR	**	$ 185,989
BARAK KOHN	ASST ADMIN	**	28,654
REBECCA KOHN	OTHER ADMIN	**	58,666
** BY ATTRIBUTION 100% KOHN FAMILY OWNED			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 273,309

B. Administrative - Other

Description		Amount
ARTHUR KOHN	MANAGEMENT FEES	$ 200,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 200,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SERVICES	DATA PROCESSING	$ 4,894
MDI ACHIEVE	DATA PROCESSING	21,076
MYRON TUSHBAI	ACCOUNTING	9,045
KBKB LLC	ACCOUNTING	20,700
RICHARD PEELO	MEDICARE COST REPORT	3,250
PERSONNEL PLANNING	UNEMPLOYMENT CONSULT	600
ADVANTAGE BENEFITS	501A CONSULTANT	1,306
LEGAL	SEE SCHEDULE	14,051
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 74,922

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 41,003
Unemployment Compensation Insurance		8,033
FICA Taxes		200,292
Employee Health Insurance		195,947
Employee Meals		11,096
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		28,675
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS (CVA)		(4,089)
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 480,957

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	$ 3,980
Advertising: Employee Recruitment	0
Health Care Worker Background Check	1,003
(Indicate # of checks performed 32)	
Patient Background Checks 8	80
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	43,138
LICENSES/DUES/SUBSCRIPTIONS	8,650
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(1,912)
Non-allowable advertising	(23,512)
Yellow page advertising	(17,714)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,713

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
SCHEDULE-LEGAL
12/31/2016

DATE	FIRM	INVOICE #	PURPOSE	COST	TOTAL COST
3.16	RIEFF SCHRAMM KANTER GUTTMAN	23201	REAL ESTATE TAX ABATEMENT-FILING FEE	225.00	
					225.00
1.16	STONE POGRUND KOREY	63576	LEGAL GUARDIANSHIP	897.63	
2.16	STONE POGRUND KOREY	64761	LEGAL GUARDIANSHIP	719.91	
3.16	STONE POGRUND KOREY	65484	LEGAL GUARDIANSHIP	1,672.50	
4.16	STONE POGRUND KOREY	66239	LEGAL GUARDIANSHIP	662.00	
5.16	STONE POGRUND KOREY	68148	LEGAL GUARDIANSHIP	200.00	
6.16	STONE POGRUND KOREY	68987	LEGAL GUARDIANSHIP	211.00	
7.16	STONE POGRUND KOREY	70085	LEGAL GUARDIANSHIP	562.50	
8.16	STONE POGRUND KOREY	71515	LEGAL GUARDIANSHIP	1,457.86	
9.16	STONE POGRUND KOREY	72598	LEGAL GUARDIANSHIP	4,363.63	
10.16	STONE POGRUND KOREY	73610	LEGAL GUARDIANSHIP	475.00	
11.16	STONE POGRUND KOREY	74321	LEGAL GUARDIANSHIP	587.50	
12.16	STONE POGRUND KOREY	75110	LEGAL GUARDIANSHIP	2,016.45	
					13,825.98
				TOTAL	**14,050.98**

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. $ **20,855** 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. $ **231,888**
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? **NO** 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. $ **11,096** 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) 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