		FOR BHF USE			

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 NURSING & REHAB CENTER LLC

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

County: COOK

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

HFS ID Number:

Date of Initial License for Current Owners: 05/01/2011

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.	X			
	Trust		Individual		State
	IRS Exemption Code		Partnership		County
			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 01/01/2017 to 12/31/2017 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 informatio 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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			2,476	2,476	8
9	SNF/PED					9
10	ICF	15,570	12,296	1,762	29,628	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,570	12,296	4,238	32,104	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.68%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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 2,476

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CE! **#** 0051508 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	203,397	15,106	302	218,805		218,805	0	218,805			1
2	Food Purchase		166,962		166,962	(11,680)	155,282	(779)	154,503			2
3	Housekeeping	64,461	44,193	0	108,654		108,654	0	108,654			3
4	Laundry	28,832	9,505	2,854	41,191		41,191	0	41,191			4
5	Heat and Other Utilities			81,140	81,140		81,140	0	81,140			5
6	Maintenance	55,906	5,638	40,299	101,843		101,843	0	101,843			6
7	Other (specify):*			8,737	8,737		8,737	0	8,737			7
8	**TOTAL General Services**	352,596	241,404	133,332	727,332	(11,680)	715,652	(779)	714,873			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	2,113,399	85,578	8,823	2,207,800		2,207,800	0	2,207,800			10
10a	Therapy	111,930	4,433	126,719	243,082		243,082	0	243,082			10a
11	Activities	99,999	21,566	0	121,565		121,565	0	121,565			11
12	Social Services	28,990		3,840	32,830		32,830	0	32,830			12
13	CNA Training			0	0		0	0	0			13
14	Program Transportation			468	468		468	0	468			14
15	Other (specify):*	0			0		0	0	0			15
16	**TOTAL Health Care and Programs**	2,354,318	111,577	151,850	2,617,745	0	2,617,745	0	2,617,745			16
	C. General Administration											
17	Administrative	273,105		224,527	497,632		497,632	(100,021)	397,611			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			65,094	65,094		65,094	(45)	65,049			19
20	Dues, Fees, Subscriptions & Promotions			50,896	50,896		50,896	(33,273)	17,623			20
21	Clerical & General Office Expenses	104,258	16,538	27,031	147,827		147,827	83	147,910			21
22	Employee Benefits & Payroll Taxes			547,434	547,434	11,680	559,114	0	559,114			22
23	Inservice Training & Education			1,380	1,380		1,380	0	1,380			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			4,246	4,246		4,246	0	4,246			25
26	Insurance-Prop.Liab.Malpractice			143,371	143,371		143,371	0	143,371			26
27	Other (specify):*	0		0	0		0	0	0			27
28	**TOTAL General Administration**	377,363	16,538	1,063,979	1,457,880	11,680	1,469,560	(133,256)	1,336,304			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,084,277	369,519	1,349,161	4,802,957	0	4,802,957	(134,035)	4,668,922			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.

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			5,700	5,700		5,700	76,817	82,517			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			5,469	5,469		5,469	102,142	107,611			32
33	Real Estate Taxes			341,679	341,679		341,679	(142,255)	199,424			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			3,619	3,619		3,619	0	3,619			36
37	**TOTAL Ownership**			1,376,467	1,376,467	0	1,376,467	(983,296)	393,171			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		88,131	176,264	264,395		264,395	0	264,395			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			232,731	232,731		232,731	0	232,731			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	88,131	408,995	497,126	0	497,126	0	497,126			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,084,277	457,650	3,134,623	6,676,550	0	6,676,550	(1,117,331)	5,559,219			45

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Reference	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	7,371	30		9
10	Interest and Other Investment Income	(6,303)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(779)	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	(250)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,070)	20		19
20	Contributions	(211)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,195)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,759)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(16,983)	20		28
29	Other-Attach Schedule SEE PG 5A	(242,626)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (276,805)		$ 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)	(840,526)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (840,526)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,117,331)		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 NURSING & REHAB CENTER LLC

ID# 0051508

Report Period Beginning: 01/01/2017
Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DISALLOWED EXCESS OWNER SALARY	$ (75,494)	17	1
2	DISALLOWED EXCESS MGMT FEES	(24,527)	17	2
3	REAL ESTATE TAX REFUND	(190,092)	33	3
4	REAL ESTATE TAX - LEGAL EXPENSE	47,837	33	4
5	DISALLOWED LEGAL-CORPORATE MATTERS	(350)	19	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**	(242,626)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(779)	0	0	0	0	0	0	0	0	0	0	(779)	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**	(779)	0	0	0	0	0	0	0	0	0	0	(779)	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	(100,021)	0	0	0	0	0	0	0	0	0	0	(100,021)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,545)	1,500	0	0	0	0	0	0	0	0	0	(45)	19
20	Fees, Subscriptions & Promotions	(33,273)	0	0	0	0	0	0	0	0	0	0	(33,273)	20
21	Clerical & General Office Expenses	0	83	0	0	0	0	0	0	0	0	0	83	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**	(134,839)	1,583	0	0	0	0	0	0	0	0	0	(133,256)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(135,618)	1,583	0	0	0	0	0	0	0	0	0	(134,035)	29

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	7,371	69,446	0	0	0	0	0	0	0	0	0	76,817	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,303)	108,445	0	0	0	0	0	0	0	0	0	102,142	32
33	Real Estate Taxes	(142,255)	0	0	0	0	0	0	0	0	0	0	(142,255)	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**	(141,187)	(842,109)	0	0	0	0	0	0	0	0	0	(983,296)	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)**	(276,805)	(840,526)	0	0	0	0	0	0	0	0	0	(1,117,331)	45

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		" "		69,446	69,446	2
3	V	32	INTEREST		" "		108,445	108,445	3
4	V	21	OFFICE EXPENSE		" "		83	83	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			$ 179,474	$ * (840,526)	14

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 NURSING & REHAB CE # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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	29,077	17-1	2
3	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	52,533	6	50.00	SALARY	58,533	17-1	3
4	CYNTHIA KOHN	BOOKKEEPER	BOOKKEEPING	0.00	57,143	4	13.00	SALARY	8,295	21-1	4
5	ARTHUR KOHN	OFFICER	MANAGEMENT	1.00	0			MGT FEE	200,000	17-3	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	$ 405,905		13

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

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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]

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

B. Show the allocation of costs below. If necessary, please attach worksheets.

	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

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	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+	$ 1,536	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	2,448,943	12/05/19	0.0325	108,535	5
	Working Capital											
6	MB FINANCIAL		X	LINE OF CREDIT		06/19/17	200,000	0			3,933	6
7												7
8												8
9	TOTAL Facility Related				$34,068.49		$ 5,766,057	$ 2,510,950			$ 114,004	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 5,766,057	$ 2,510,950			$ 114,004	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # ______

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2016 report.	$	231,600	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.)	$	285,279	2
3. Under or (over) accrual (line 2 minus line 1).	$	53,679	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	288,000	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.)**	$	47,837	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** $ 109,092 **For** 8-14 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	(190,092)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	199,424	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2012	205,168	8
2013	223,708	9
2014	228,996	10
2015	231,211	11
2016	285,279	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 2016 real estate tax bill.

FOR BHF USE ONLY

Line	Description		Line
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOBSON PLAZA NURSING & REHAB CENTER LLC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051508

CONTACT PERSON REGARDING THIS REPORT 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-113-043-0000	NURSING HOME	$ 284,751.29	$ 284,751.29
2.	10-25-220-015-0000	NURSING HOME	$ 527.52	$ 527.52
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 285,278.81	$ 285,278.81

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

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	2	3	4	
	Use	Square Feet	Year Acquired	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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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)	707,233	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)	280,854	25
26	CANOPY SIGN			1999	8,000	205	39	205		3,767	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		6,733	28
29	ELEVATOR UPGRADE / AIR INTAKES		per audit -10,038	2000	18,221	1,028	27.5	1,028		17,605	29
30	ELEVATOR UPGRADE		per audit -756	2001	18,221	690	27.5	690		11,586	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		6,201	32
33	HYDRAULIC ELEVATOR PUMP			2006	10,772	392	27.5	392		4,622	33
34	BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER			2006	29,463	1,071	27.5	1,071		12,423	34
35	NURSG STN/BATHRMS/PLUMBG/FLOORING/ROOF FASCIA			2007	53,627	1,950	27.5	1,950		20,555	35
36	BEAUTY SHOP DRYWALL,CABINETRY,PLUMBING,TILE			2007	7,287	264	27.5	264		2,638	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$	$ 3,025	37
38	PT,AAD,DAYRMS-DRYWALL,FLOORING,STUDS,JOIST	2008	19,380	705	27.5	705		6,903	38
39	BATHRMS:TILE,FLOOR,DRYWALL,PAINT,PAPER,FIXTURES	2008	15,425	561	27.5	561		5,407	39
40	REPIPE KITCHEN WATER LINES	2008	2,065	75	27.5	75		730	40
41	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	109	27.5	109		1,042	41
42	LOWER LEVEL BATHROOM PROJECT	2008	26,300	956	27.5	956		8,739	42
43	LOWER LEVEL NURSING STATION	2008	12,500	455	27.5	455		4,152	43
44	UPPER ROOF REPLACEMENT	2008	18,500	673	27.5	673		6,141	44
45	CARPETING	2008	11,259		10	1,122	1,122	11,259	45
46	DRIVEWAY/PARKINGLOT	2008	18,807	1,254	15	1,254		11,912	46
47	THERAPY ROOM WALL/SHELVING/CARPENTRY/6 DOORS	2009	5,530	201	27.5	201		1,792	47
48	2ND FLOOR ROOF/5-TON AC CONDENSER per audit -1,300	2009	11,025	443	27.5	443		3,880	48
49	SECURITY SYSTEM/CABLES/WANDERGUARD WIRING	2009	5,671	206	27.5	206		1,784	49
50	CARPENTRY/RECESSED LIGHTING/WIRING 28 OUTLETS	2009	7,975	290	27.5	290		2,405	50
51	SUMP PUMP MOTOR & PIPELINES	2009	3,700	135	27.5	135		1,121	51
52	CERAMIC FLOOR/CARPENTRY/CLOSET/INTERCOM/CABLE	2009	2,919	108	27.5	108		869	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		2,470	54
55	NURSING STATION BUILT-INS/DRYWALL per audit -900	2010	5,011	215	27.5	215		1,478	55
56	DELAYED ELEVATOR EGRESS LOCKS	2010	3,868	141	27.5	141		1,075	56
57	WALLPAPER/CARPETING/COVE BASE/BASEBOARDS	2010	12,741		10	1,274	1,274	9,555	57
58	SUMP PUMP per audit -5,119	2010	2,600	281	27.5	281		2,026	58
59	WEIL PUMP 2224	2011	5,119		10	512	512	3,328	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		1,375	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 per audit - 2,231	2012	48,520	1,845	27.5	1,845		10,071	64
65	A/C FOR DINING ROOM	2012	3,120	113	27.5	113		617	65
66	WIRING	2014	5,597	204	27.5	204		739	66
67	SECURITY SYSTEM UPGRADES	2015	3,100	298	5	620	322	1,421	67
68	ELEVATOR-RETRACTABLE LADDER & WIRING	2015	4,026	146	27.5	146		335	68
69	2ND FL CORRIDOR & DAYROOM FLOORING	2015	18,961	689	27.5	689		1,405	69
70	TOTAL (lines 4 thru 69)		$ 2,510,026	$ 71,664		$ 57,206	$ (14,458)	$ 1,779,915	70

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		$ 2,510,026	$ 71,664		$ 57,206	$ (14,458)	$ 1,779,915	1
2	HOT WATER TANK, INSTALLATION per audit -553	2016	10,253	373	27.5	373		637	2
3	1ST FLOOR CORRIDOR GLUE-DOWN CARPETING	2016	3,694	134	27.5	134		229	3
4	ELEVATOR MAIN CONTROL VALVE	2016	6,500	236	27.5	236		364	4
5	Nurses Station	2017	14,300	498	27.5	498		498	5
6	Kohler 20EOZK Generator	2017	50,000	1,591	27.5	1,591		1,591	6
7	2nd Floor dayroom PVT flooring & cove base	2017	5,424	156	27.5	156		156	7
8	3rd Floor corridor carpeting	2017	5,221	119	27.5	119		119	8
9	South rooftop cooling/heating unit	2017	14,915	248	27.5	248		248	9
10	Installation of shunt trip unit in elevator	2017	5,643	26	27.5	26		26	10
11									11
12									12
13	ADJUST TO STRAIGHT LINE			(14,458)			14,458		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)		$ 2,625,976	$ 60,587		$ 60,587	$ 0	$ 1,783,783	34

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER I# 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 82,731	$ 8,859	$ 8,859	$ 0	5-10 YRS	$ 54,960	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 82,731	$ 8,859	$ 8,859	$ 0		$ 54,960	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	$ 5,700	$ 13,071	$ 7,371	5	$ 18,517	76
77	ACTIVITIES,MAINT,						0			77
78	& PURCHASING,ETC						0			78
79							0			79
80	TOTALS			$ 65,357	$ 5,700	$ 13,071	$ 7,371		$ 18,517	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)	$ 2,854,573	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 75,146	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 82,517	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,371	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,857,260	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.

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.	/2018	$
13.	/2019	$
14.	/2020	$

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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 50,903	$		$ 50,903	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			35,026			35,026	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			90,335			90,335	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				77,595		77,595	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					10,536		10,536	13
14	TOTAL			$		$ 176,264	$ 88,131		$ 264,395	14

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 263,160	$ 562,081	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,632,041	1,632,041	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		573,903	5
6	Prepaid Insurance	92,728	92,728	6
7	Other Prepaid Expenses	2,552	3,771	7
8	Accounts Receivable (owners or related parties)		784,085	8
9	Other(specify): DUE DOBSON PLAZA INC	621,264	0	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,611,745	$ 3,648,609	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		751,878	15
16	Equipment, at Historical Cost	65,357	206,167	16
17	Accumulated Depreciation (book methods)	(17,260)	(2,141,872)	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): NYL INSUR.CONTRACTS	312,306	312,306	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 360,403	$ 1,291,269	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,972,148	$ 4,939,878	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 204,442	$ 235,249	26
27	Officer's Accounts Payable	224,527	224,527	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	92,966	92,966	29
30	Accrued Salaries Payable	137,945	137,945	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,178	22,178	31
32	Accrued Real Estate Taxes(Sch.IX-B)		288,000	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)**	$ 682,058	$ 1,300,865	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	48,239	48,239	39
40	Mortgage Payable		2,148,943	40
41	Bonds Payable			41
42	Deferred Compensation	1,117,131	1,117,131	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,165,370	$ 3,314,313	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,847,428	$ 4,615,178	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,124,720	$ 324,700	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,972,148	$ 4,939,878	48

*(See instructions.)

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,547,095	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,547,095	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,053,058	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	(1,457,990)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Real estate tax- legal offset to refund	(17,443)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (422,375)	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)**	$ 1,124,720	24 *

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 7,353,354	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,353,354	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	383,603	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 383,603	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		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)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,303	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,303	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)**	$ 7,743,260	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	727,332	31
32	Health Care	2,617,745	32
33	General Administration	1,457,880	33
	B. Capital Expense		
34	Ownership	1,376,467	34
	C. Ancillary Expense		
35	Special Cost Centers	264,395	35
36	Provider Participation Fee	232,731	36
	D. Other Expenses (specify):		
37	BARBER & BEAUTICIAN	1,972	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,678,522	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,064,738	41
42	**Income Taxes**	(11,680)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,053,058	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,643,254	44
45	Private Pay - Net Inpatient Revenue	2,923,930	45
46	Medicare - Net Inpatient Revenue	1,448,978	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	337,192	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,353,354	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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,907	2,162	$ 106,257	$ 49.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,831	25,841	823,218	31.86	3
4	Licensed Practical Nurses	4,398	5,041	130,888	25.96	4
5	CNAs & Orderlies	57,506	64,067	820,229	12.80	5
6	CNA Trainees					6
7	Licensed Therapist	2,245	2,245	111,930	49.86	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,664	2,871	51,685	18.00	9
10	Activity Assistants	3,469	3,498	48,314	13.81	10
11	Social Service Workers	1,158	1,303	28,990	22.25	11
12	Dietician					12
13	Food Service Supervisor	1,967	2,055	64,226	31.25	13
14	Head Cook	279	279	4,284	15.35	14
15	Cook Helpers/Assistants	11,424	12,564	134,887	10.74	15
16	Dishwashers					16
17	Maintenance Workers	3,560	4,223	55,906	13.24	17
18	Housekeepers	4,990	5,573	64,461	11.57	18
19	Laundry	2,340	2,680	28,832	10.76	19
20	Administrator	2,086	2,086	185,495	88.92	20
21	Assistant Administrator	1,043	1,043	29,077	27.88	21
22	Other Administrative	1,042	1,042	58,533	56.17	22
23	Office Manager					23
24	Clerical	4,801	5,146	104,258	20.26	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	1,925	2,150	74,415	34.61	31
32	Other Health Ca ADMISSION/QA	4,401	4,401	158,392	35.99	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,036	150,270	$ 3,084,277 *	$ 20.52	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 302	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	4,800	10-3	37
38	Nurse Consultant	T	4,023	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	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)		$ 21,125		49

C. CONTRACT NURSES

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER I # 0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLOTTE KOHN	ADMINISTRATOR	**	$ 185,495
BARAK KOHN	ASST ADMIN	**	29,077
REBECCA KOHN	OTHER ADMIN	**	58,533
** BY ATTRIBUTION 100% KOHN FAMILY OWNED			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 273,105

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SERVICES	DATA PROCESSING	$ 5,892
ESOLUTIONS	DATA PROCESSING	2,315
MDI ACHIEVE	DATA PROCESSING	19,319
MYRON TUSHBAI	ACCOUNTING	5,832
KBKB LLC	ACCOUNTING	18,723
RICHARD PEELO	MEDICARE COST REPORT	3,250
PERSONNEL PLANNING	UNEMPLOYMENT CONSULT	450
ADVANTAGE BENEFITS	501A CONSULTANT	1,436
SEE LEGAL SCHEDULE ATTACHED		7,877
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 65,094

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 44,992
Unemployment Compensation Insurance		11,292
FICA Taxes		244,524
Employee Health Insurance		249,421
Employee Meals		11,680
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		624
EMPLOYEE PHYSICAL EXAMS		43
PENSION/PROFIT SHARING PLANS (CVA)		(3,462)
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 559,114

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$
Advertising: Employee Recruitment		8,040
Health Care Worker Background Check		930
(Indicate # of checks performed	13)	
Patient Background Checks	41	410
TRUST/FRANCHISE/CONTRIB/ETC		461
MARKETING/ADV/PROMO		32,812
LICENSES/DUES/SUBSCRIPTIONS		8,243
TRUST/FRANCHISE/CONTRIB/ETC		(461)
Less: Public Relations Expense		(3,070)
Non-allowable advertising		(12,759)
Yellow page advertising		(16,983)
TOTAL (agree to Sch. V, line 20, col. 8)		$ 17,623

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.

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. $ 25,099 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. $ 232,731
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. $ 11,680 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

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	302	
	REPAIRS & MAINTENANCE		0	
				302
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,854	
				2,854
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		13,853	
	ELECTRICITY		31,523	
	WATER		30,030	
	CABLE TV - LOBBY		5,734	
				81,140
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,002	
	PAINTING & DECORATING		686	
	BUILDING REPAIRS		2,095	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		12,745	
	ELEVATOR MAINTENANCE & REPAIR		6,055	
	OUTSIDE LABOR		1,684	
	EXTERMINATING SERVICE		2,976	
	FIRE SERVICE		6,056	
				40,299
7	**OTHER**			
	SCAVENGER		8,737	
	SECURITY SERVICE		0	
				8,737
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	4,800	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	4,023	
				8,823
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		81,650	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		45,069	
	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	
				126,719
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
				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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC #0051508 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		468	
				468
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	224,527	224,527
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	27,526	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	37,568	
				65,094
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	3,070	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	12,759	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	8,040	
	CONTRIBUTIONS	VI 20 XIX F	211	
	DUES & SUBSCRIPTIONS	XIX F	0	
	LICENSES & PERMITS	XIX F	8,243	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	16,983	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	250	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	1,260	
	PATIENT BACKGROUND CHECKS	XIX F	80	
				50,896
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		9,744	
	OUTSIDE CLERICAL SERVICES		3,701	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		13,586	
	MESSENGER SERVICE		0	
				27,031

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	244,524	
	UNEMPLOYMENT COMPENSATION	XIX D	11,292	
	WORKERS COMPENSATION INSURANC	XIX D	44,992	
	HOSPITALIZATION INSURANCE	XIX D	249,421	
	EMPLOYEE BENEFITS - OTHER	XIX D	624	
	EMPLOYEE PHYSICAL EXAMS	XIX D	43	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	501 PLAN - CASH VALUE ADJ	XIX D	(3,462)	
				547,434
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,380	
				1,380
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,246	
				4,246
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		143,371	
				143,371
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **1,349,161**

DOBSON PLAZA NURSING & REHAB CENTER LLC
SCHEDULES
12/31/2017

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

TOTAL FOOD PURCHASE	166,962
LESS SALES TAX	(779)
NET FOOD	166,183
TOTAL PATIENT CENSUS	32,104
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	96,312
ADD # EMPLOYEE MEALS/DAY	20
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	7,300
PATIENT MEALS	96,312
ADD EMPLOYEE MEALS	7,300
TOTAL MEALS/YEAR	103,612
NET FOOD	166,183
DIVIDE TOTAL MEALS/YEAR	103,612
COST PER MEAL	1.60
TIMES EMPLOYEE MEALS	7,300
EMPLOYEE MEAL RECLASSIFICATION	**11,680**

Supplement to Page 10 - Summary of Real Estate Tax Refunds

Refund	Legal Expense	Year	Net	
	260.00	<FILING FEE		DOBSON PLAZA NURSING & REHAB CENTER LLC
34,375.70	8,602.92	2014	25,772.78	DOBSON PLAZA NURSING & REHAB CENTER LLC
34,288.14	8,581.04	2013	25,707.10	DOBSON PLAZA NURSING & REHAB CENTER LLC
41,515.31	10,387.83	2012	31,127.48	DOBSON PLAZA INC
38,077.96	9,528.49	2011	28,549.47	DOBSON PLAZA INC
31,226.98	7,815.74	2009	23,411.24	DOBSON PLAZA INC
10,607.44	2,660.86	2008	7,946.58	DOBSON PLAZA INC
190,091.53	47,836.88		142,514.65	

DOBSON PLAZA NURSING & REHAB CENTER LLC
SCHEDULE-LEGAL
12/31/2017

DATE	FIRM	INVOICE #	PURPOSE	COST	TOTAL COST
1.17	RIEFF SCHRAMM KANTER GUTTMAN	01242017	REAL ESTATE TAX ABATEMENT-FILING FEE	260.00	
8.17	RIEFF SCHRAMM KANTER GUTTMAN	M47518frm	REAL ESTATE TAX REFUND-LEGAL '13	8,581.04	
8.17	RIEFF SCHRAMM KANTER GUTTMAN	M47517frm	REAL ESTATE TAX REFUND-LEGAL '14	8,602.92	
	Real Estate Tax - legal		reported on page 10	(17,443.96)	0.00
01.31.17	STONE POGRUND KOREY	76000	LEGAL GUARDIANSHIP	1,387.50	
02.28.17	STONE POGRUND KOREY	77835	LEGAL GUARDIANSHIP	1,486.16	
03.31.17	STONE POGRUND KOREY	79536	LEGAL GUARDIANSHIP	128.34	
10.31.17	STONE POGRUND KOREY	85615	LEGAL GUARDIANSHIP	25.00	
11.30.17	STONE POGRUND KOREY	86466	LEGAL GUARDIANSHIP	25.00	
					3,052.00
11.30.17	SEGAL & SEGAL	FEB-SEP	LEGAL GUARDIANSHIP		4,474.50
8.28.17	MUCH SHELIST	471076	CORPORATE MATTERS		350.00
				TOTAL	**7,876.50**
DISALLOWED ON PAGE 5:					
8.28.17	MUCH SHELIST	471076	CORPORATE MATTERS		(350.00)
					7,526.50