Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			1,773	1,773	8
9	SNF/PED					9
10	ICF	15,824	10,537	1,073	27,434	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,824	10,537	2,846	29,207	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.49%

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 7/1/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 0

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CE # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	208,244	16,146		224,390		224,390		224,390			1
2	Food Purchase		163,539		163,539	(12,483)	151,056	(845)	150,211			2
3	Housekeeping	84,665	48,026		132,691		132,691		132,691			3
4	Laundry	30,897	7,782	5,738	44,417		44,417		44,417			4
5	Heat and Other Utilities			80,976	80,976		80,976		80,976			5
6	Maintenance	57,205	2,783	47,412	107,400		107,400		107,400			6
7	Other (specify):*			8,752	8,752		8,752		8,752			7
8	**TOTAL General Services**	381,011	238,276	142,878	762,165	(12,483)	749,682	(845)	748,837			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,112,995	96,411	7,625	2,217,031		2,217,031		2,217,031			10
10a	Therapy	265,049			265,049		265,049		265,049			10a
11	Activities	98,587	9,080		107,667		107,667		107,667			11
12	Social Services	26,034		3,840	29,874		29,874		29,874			12
13	CNA Training											13
14	Program Transportation			1,066	1,066		1,066		1,066			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,502,665	105,491	24,531	2,632,687		2,632,687		2,632,687			16
	C. General Administration											
17	Administrative	257,890		206,230	464,120		464,120	(76,230)	387,890			17
18	Directors Fees											18
19	Professional Services			71,400	71,400		71,400	1,072	72,472			19
20	Dues, Fees, Subscriptions & Promotions			65,318	65,318		65,318	(41,782)	23,536			20
21	Clerical & General Office Expenses	169,303	25,986	30,469	225,758		225,758	145	225,903			21
22	Employee Benefits & Payroll Taxes			533,276	533,276	12,483	545,759		545,759			22
23	Inservice Training & Education			1,093	1,093		1,093		1,093			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			8,448	8,448		8,448		8,448			25
26	Insurance-Prop.Liab.Malpractice			143,400	143,400		143,400		143,400			26
27	Other (specify):* BAD DEBTS			49,285	49,285		49,285	(17,370)	31,915			27
28	**TOTAL General Administration**	427,193	25,986	1,108,919	1,562,098	12,483	1,574,581	(134,165)	1,440,416			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,310,869	369,753	1,276,328	4,956,950		4,956,950	(135,010)	4,821,940			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: DOBSON PLAZA NURSING & REHAB CENTER LLC #0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2		
	REPAIRS & MAINTENANCE			
				0
3	**HOUSEKEEPING**			
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,738	
				5,738
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		16,685	
	ELECTRICITY		32,092	
	WATER		24,368	
	CABLE TV - LOBBY		7,831	
				80,976
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,657	
	PAINTING & DECORATING		636	
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR		8,733	
	ELEVATOR MAINTENANCE & REPAIR		24,725	
	OUTSIDE LABOR		58	
	EXTERMINATING SERVICE		5,106	
	FIRE SERVICE		5,497	
				47,412
7	**OTHER**			
	SCAVENGER		8,752	
	SECURITY SERVICE			
				8,752
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			
	PURCHASED SERVICES			
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2		
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	2,825	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,800	
	PHARMACY CONSULTANT	XVIII B 39-2		
	UTILIZATION REVIEW FEES	XVIII B __-2		
	PHYSICIANS	XVIII B __-2		
	PSYCHIATRIC	XVIII B __-2		
	RN CONSULTANT	XVIII B 38-2		
				7,625
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2		
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2		
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2		
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2		
	SPEECH THERAPY CONSULTANT	XVIII B 43-2		
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2		
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2		
	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:** 01/01/2018 **Ending:** 12/31/2018

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,066	
				1,066
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	206,230	206,230
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	31,883	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	39,517	
				71,400
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	25,746	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	11,700	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F		
	LICENSES & PERMITS	XIX F	11,240	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	15,961	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	75	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F		
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	596	
	PATIENT BACKGROUND CHECKS	XIX F		
				65,318
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,733	
	EQUIPMENT REPAIR & MAINTENANCE		5,379	
	OUTSIDE CLERICAL SERVICES		4,827	
	PENALTIES / OVERDRAFT CHARGES	VI 18		
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE		18,530	
	MESSENGER SERVICE			
				30,469

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	254,344	
	UNEMPLOYMENT COMPENSATION	XIX D	9,873	
	WORKERS COMPENSATION INSURANC	XIX D	42,000	
	HOSPITALIZATION INSURANCE	XIX D	224,337	
	EMPLOYEE BENEFITS - OTHER	XIX D	550	
	EMPLOYEE PHYSICAL EXAMS	XIX D	5,234	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D		
	501 PLAN - CASH VALUE ADJ		(3,062)	
				533,276
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,093	
				1,093
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G		
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,039	
	AUTO EXPENSES - OTHER		4,409	8,448
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		143,400	
				143,400
27	**OTHER**			
	BAD DEBTS	VI 24	49,285	
				49,285

GRAND TOTAL COLUMN 3 OTHER **1,276,328**

DOBSON PLAZA NURSING & REHAB CENTER LLC
SCHEDULES
12/31/2018

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

TOTAL FOOD PURCHASE	163,539
LESS SALES TAX	(845)
NET FOOD	162,694
TOTAL PATIENT CENSUS	29,207
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	87,621
ADD # EMPLOYEE MEALS/DAY	20
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	7,300
PATIENT MEALS	87,621
ADD EMPLOYEE MEALS	7,300
TOTAL MEALS/YEAR	94,921
NET FOOD	162,694
DIVIDE TOTAL MEALS/YEAR	94,921
COST PER MEAL	1.71
TIMES EMPLOYEE MEALS	7,300
EMPLOYEE MEAL RECLASSIFIC	**12,483**

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC #0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			3,350	3,350		3,350	18,580	21,930			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,093	2,093		2,093	25,415	27,508			32
33	Real Estate Taxes			308,611	308,611		308,611		308,611			33
34	Rent-Facility & Grounds			1,020,000	1,020,000		1,020,000	(1,020,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			4,101	4,101		4,101		4,101			36
37	**TOTAL Ownership**			1,338,155	1,338,155		1,338,155	(976,005)	362,150			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	265,049	55,934		320,983		320,983		320,983			39
40	Barber and Beauty Shops			4,327	4,327		4,327		4,327			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			222,159	222,159		222,159		222,159			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	265,049	55,934	226,486	547,469		547,469		547,469			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,575,918	425,687	2,840,969	6,842,574		6,842,574	(1,111,015)	5,731,559			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: 01/01/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,721	30		9
10	Interest and Other Investment Income	(66,686)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(845)	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	(75)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,370)	27		24
25	Fund Raising, Advertising and Promotional	(25,746)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(15,961)	20		28
29	Other-Attach Schedule SEE PG 5A	(76,658)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (193,620)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (193,620)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
DOBSON PLAZA NURSING & REHAB CENTER LLC
ID# 0051508
Report Period Beginning: 01/01/2018
Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DISALLOWED EXCESS OWNER SALARY	$ (70,000)	17	1
2	DISALLOWED EXCESS MGMT FEES	(6,230)	17	2
3	DISALLOWED LEGAL-CORPORATE MATTERS	(428)	19	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**	(76,658)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(845)	0	0	0	0	0	0	0	0	0	0	(845)	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**	(845)	0	0	0	0	0	0	0	0	0	0	(845)	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	(76,230)	0	0	0	0	0	0	0	0	0	0	(76,230)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(428)	1,500	0	0	0	0	0	0	0	0	0	1,072	19
20	Fees, Subscriptions & Promotions	(41,782)	0	0	0	0	0	0	0	0	0	0	(41,782)	20
21	Clerical & General Office Expenses	0	145	0	0	0	0	0	0	0	0	0	145	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):*	(17,370)	0	0	0	0	0	0	0	0	0	0	(17,370)	27
28	**TOTAL General Administration**	(135,810)	1,645	0	0	0	0	0	0	0	0	0	(134,165)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(136,655)	1,645	0	0	0	0	0	0	0	0	0	(135,010)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	9,721	8,859	0	0	0	0	0	0	0	0	0	18,580	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(66,686)	92,101	0	0	0	0	0	0	0	0	0	25,415	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	(56,965)	(919,040)	0	0	0	0	0	0	0	0	0	(976,005)	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)	(193,620)	(917,395)	0	0	0	0	0	0	0	0	0	(1,111,015)	45

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	EVANSTON	REAL ESTATE
ARTHUR J KOHN	1%					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		" "		8,859	8,859	2
3	V	32	INTEREST	5,046	" "		97,147	92,101	3
4	V	21	OFFICE EXPENSE		" "		145	145	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			$ 1,025,046			$ 107,651	$ * (917,395)	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: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018 Ending: 12/31/2018

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 Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
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	10,625	18	60.00	SALARY	28,500	17-1	2
3	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	53,400	6	50.00	SALARY	58,400	17-1	3
4	CYNTHIA KOHN	BOOKKEEPER	BOOKKEEPING	0.00	57,000	4	13.00	SALARY	47,504	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	$ 444,404		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: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CEN # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 35,274	08/16/21	PRIME+	$ 1,268	1
2												2
3	RELATED PARTY - DOBSON PLAZA INC:											3
4	MB FINANCIAL		X	MORTGAGE	$7,188.35+Int	12/16/04	2,148,943		12/5/18	0.0325	79,445	4
5	MB FINANCIAL		X	MORTGAGE RENEWAL	$32,880.35	10/16/08	4,500,000	4,478,435	12/05/19	PRIME+	49,462	5
	Working Capital											
6	MB FINANCIAL		X	LINE OF CREDIT		06/19/17	200,000				800	6
7												7
8												8
9	TOTAL Facility Related				$34,068.49		$ 6,915,000	$ 4,513,709			$ 130,975	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,915,000	$ 4,513,709			$ 130,975	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ 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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 288,000	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.)		$ 300,851	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,851	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 303,860	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.		$ 316,711	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	223,708	8
	2014	228,996	9
	2015	231,211	10
	2016	285,279	11
	2017	300,851	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 KATHLEEN MCNAMARA

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-113-043-0000	NURSING HOME	$ 300,295.11	$ 300,295.11
2.	10-25-220-015-0000	NURSING HOME	$ 556.29	$ 556.29
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 300,851.40	$ 300,851.40

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		40	23,268	23,268	730,501	6
7	2			1971	11,147		8-12			11,147	7
8	4	per audit -64011		1987			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			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			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)	294,228	25
26	CANOPY SIGN			1999	8,000	205	39	205		3,972	26
27	ELEVATOR REPAIR	per audit -1,990		1999		51	39		(51)		27
28	FIRE DAMPERS / AIR INTAKES			2000	10,515	382	27.5	382		7,115	28
29	ELEVATOR UPGRADE / AIR INTAKES	per audit -10,038		2000	18,221	1,028	27.5	1,028		18,221	29
30	ELEVATOR UPGRADE	per audit -756		2001	18,221	690	27.5	690		12,276	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		6,622	32
33	HYDRAULIC ELEVATOR PUMP			2006	10,772	392	27.5	392		5,014	33
34	BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER			2006	29,463	1,071	27.5	1,071		13,494	34
35	NURSG STN/BATHRMS/PLUMBG/FLOORING/ROOF FASCIA			2007	53,627	1,950	27.5	1,950		22,505	35
36	BEAUTY SHOP DRYWALL,CABINETRY,PLUMBING,TILE			2007	7,287	264	27.5	264		2,902	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: 01/01/2018 Ending: 12/31/2018

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	$	$ 3,331	37
38	PT,AAD,DAYRMS-DRYWALL,FLOORING,STUDS,JOIST	2008	19,380	705	27.5	705		7,608	38
39	BATHRMS:TILE,FLOOR,DRYWALL,PAINT,PAPER,FIXTURE	2008	15,425	561	27.5	561		5,968	39
40	REPIPE KITCHEN WATER LINES	2008	2,065	75	27.5	75		805	40
41	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	109	27.5	109		1,151	41
42	LOWER LEVEL BATHROOM PROJECT	2008	26,300	956	27.5	956		9,695	42
43	LOWER LEVEL NURSING STATION	2008	12,500	455	27.5	455		4,607	43
44	UPPER ROOF REPLACEMENT	2008	18,500	673	27.5	673		6,814	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		13,166	46
47	THERAPY ROOM WALL/SHELVING/CARPENTRY/6 DOORS	2009	5,530	201	27.5	201		1,993	47
48	2ND FLOOR ROOF/5-TON AC CONDENSER per audit -1,300	2009	11,025	443	27.5	443		4,323	48
49	SECURITY SYSTEM/CABLES/WANDERGUARD WIRING	2009	5,671	206	27.5	206		1,990	49
50	CARPENTRY/RECESSED LIGHTING/WIRING 28 OUTLETS	2009	7,975	290	27.5	290		2,695	50
51	SUMP PUMP MOTOR & PIPELINES	2009	3,700	135	27.5	135		1,256	51
52	CERAMIC FLOOR/CARPENTRY/CLOSET/INTERCOM/CABLI	2009	2,919	108	27.5	108		977	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		2,787	54
55	NURSING STATION BUILT-INS/DRYWALL per audit -900	2010	5,011	215	27.5	215		1,693	55
56	DELAYED ELEVATOR EGRESS LOCKS	2010	3,868	141	27.5	141		1,216	56
57	WALLPAPER/CARPETING/COVE BASE/BASEBOARDS	2010	12,741		10	1,274	1,274	10,829	57
58	SUMP PUMP per audit -5,119	2010	2,600	281	27.5	281		2,307	58
59	WEIL PUMP 2224	2011	5,119		10	512	512	3,840	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		1,580	61
62	1ST FL NURSING STATION SOCKETS/LIGHTING/BUILT-IN KITCHEN CABINETS/BATHROOM TILEWORK,PIPING,DRYWALL/LIBRARY DUCT								62
63	& SEAL WINDOWS/1ST FL BATHROOM DEMOLITION-NEW DRYWALL/SOFFITS/CONCRETE/PLUMBING/ELECTRIC/TILING/FIXTURES/PRI								63
64	ROOM FLOORING per audit - 2,231	2012	48,520	1,845	27.5	1,845		11,916	64
65	A/C FOR DINING ROOM	2012	3,120	113	27.5	113		730	65
66	WIRING	2014	5,597	204	27.5	204		943	66
67	SECURITY SYSTEM UPGRADES	2015	3,100	298	5	620	322	2,041	67
68	ELEVATOR-RETRACTABLE LADDER & WIRING	2015	4,026	146	27.5	146		481	68
69	2ND FL CORRIDOR & DAYROOM FLOORING	2015	18,961	689	27.5	689		2,094	69
70	TOTAL (lines 4 thru 69)		$ 2,510,026	$ 33,565		$ 57,206	$ 23,641	$ 1,835,587	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: 01/01/2018 Ending: 12/31/2018

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	$ 33,565		$ 57,206	$ 23,641	$ 1,835,587	1
2	HOT WATER TANK, INSTALLATION per audit -553	2016	10,253	373	27.5	373		1,010	2
3	1ST FLOOR CORRIDOR GLUE-DOWN CARPETING	2016	3,694	134	27.5	134		363	3
4	ELEVATOR MAIN CONTROL VALVE	2016	6,500	236	27.5	236		600	4
5	Nurses Station	2017	14,300	498	27.5	498		1,018	5
6	Kohler 20EOZK Generator	2017	50,000	1,591	27.5	1,591		3,409	6
7	2nd Floor dayroom PVT flooring & cove base	2017	5,424	156	27.5	156		353	7
8	3rd Floor corridor carpeting	2017	5,221	119	27.5	119		309	8
9	South rooftop cooling/heating unit	2017	14,915	248	27.5	248		790	9
10	Installation of shunt trip unit in elevator	2017	5,643	26	27.5	26		231	10
11									11
12									12
13	ADJUST TO STRAIGHT LINE			23,641			(23,641)		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	$	$ 1,843,670	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 # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$	5-10 YRS	$ 62,530	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 82,731	$ 8,859	$ 8,859	$		$ 62,530	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	$ 3,350	$ 13,071	$ 9,721	5	$ 31,588	76
77	ACTIVITIES,MAINT,									77
78	& PURCHASING,ETC									78
79										79
80	TOTALS			$ 65,357	$ 3,350	$ 13,071	$ 9,721		$ 31,588	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)	$ 72,796	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)	$ 9,721	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,937,788	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: 01/01/2018 Ending: 12/31/2018

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	10a-1	1264 hrs	$ 63,199		$	$	1,264	$ 63,199	1
2	Licensed Speech and Language Development Therapist	10a-1	641 hrs	32,105				641	32,105	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-1	3054 hrs	169,745				3,054	169,745	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				44,304		44,304	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					11,630		11,630	13
14	TOTAL			$ 265,049		$	$ 55,934	4,959	$ 320,983	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: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 729,937	$ 2,959,907	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	571,434	571,434	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		445,702	5
6	Prepaid Insurance	159,230	159,230	6
7	Other Prepaid Expenses	16,754	172,487	7
8	Accounts Receivable (owners or related parties)		784,085	8
9	Other(specify): DUE DOBSON PLAZA INC	965,828	410,429	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,443,183	$ 5,503,274	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		708,678	15
16	Equipment, at Historical Cost	65,357	206,167	16
17	Accumulated Depreciation (book methods)	(20,610)	(2,225,044)	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 (spc L/IMPR-IN PROGRESS		578,653	22
23	Other(specify): 501K LIFE INS.CONTRACTS	315,368	312,306	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 360,115	$ 1,743,550	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,803,298	$ 7,246,824	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 368,701	$ 434,564	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	92,966	92,966	29
30	Accrued Salaries Payable	121,479	121,479	30
31	Accrued Taxes Payable (excluding real estate taxes)	50,801	50,801	31
32	Accrued Real Estate Taxes(Sch.IX-B)		344,400	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		13,823	35
	Other Current Liabilities(specify):			
36	MORTGAGE PAYABLE		86,260	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 633,947	$ 1,144,293	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	35,274	35,274	39
40	Mortgage Payable		4,338,070	40
41	Bonds Payable			41
42	Deferred Compensation	1,102,501	1,102,501	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,137,775	$ 5,475,845	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,771,722	$ 6,620,138	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,031,576	$ 626,686	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,803,298	$ 7,246,824	48

*(See instructions.)

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,124,720	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,124,720	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	176,086	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	(522,023)	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)**	$ (345,937)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 778,783	24 *

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

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,664,100	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,664,100	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	266,177	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 266,177	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,327	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,327	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	66,686	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 66,686	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,001,290	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	762,165	31
32	Health Care	2,632,687	32
33	General Administration	1,562,098	33
	B. Capital Expense		
34	Ownership	1,338,155	34
	C. Ancillary Expense		
35	Special Cost Centers	325,310	35
36	Provider Participation Fee	222,159	36
	D. Other Expenses (specify):		
37	W/O BAD DEBTS	(17,370)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,825,204	40
41	**Income before Income Taxes (line 30 minus line 40)****	176,086	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 176,086	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,748,851	44
45	Private Pay - Net Inpatient Revenue	2,640,826	45
46	Medicare - Net Inpatient Revenue	1,008,046	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	266,377	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,664,100	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: 01/01/2018 Ending: 12/31/2018

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	1,738	2,003	$ 97,117	$ 48.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,714	25,531	811,597	31.79	3
4	Licensed Practical Nurses	4,158	4,811	125,849	26.16	4
5	CNAs & Orderlies	56,634	62,804	844,904	13.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,959	4,959	265,049	53.45	8
9	Activity Director	1,451	1,576	28,376	18.01	9
10	Activity Assistants	4,478	4,498	70,211	15.61	10
11	Social Service Workers	1,027	1,170	26,034	22.25	11
12	Dietician					12
13	Food Service Supervisor	1,943	2,138	71,454	33.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,242	11,290	136,790	12.12	15
16	Dishwashers					16
17	Maintenance Workers	3,511	4,175	57,205	13.70	17
18	Housekeepers	6,271	6,975	84,665	12.14	18
19	Laundry	2,433	2,794	30,897	11.06	19
20	Administrator	1,989	1,989	172,088	86.52	20
21	Assistant Administrator					21
22	Other Administrative	2,037	2,037	85,802	42.12	22
23	Office Manager					23
24	Clerical	6,478	6,980	169,303	24.26	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	1,877	2,142	74,137	34.61	31
32	Other Health C: Admissions/QA	3,887	3,978	159,391	40.07	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,827	151,850	$ 3,310,869 *	$ 21.80	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	$ 0	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	2,825	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)		$ 19,625		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 NURSING & REHAB CENTER # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLOTTE KOHN	ADMINISTRATOR	**	$ 172,088
BARAK KOHN	ASST ADMIN	**	27,269
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.)			$ 257,890

B. Administrative - Other

Description		Amount
ARTHUR KOHN	OFFICER/OWNER 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	$ 6,483
ESOLUTIONS	DATA PROCESSING	3,596
MDI ACHIEVE	DATA PROCESSING	21,804
MYRON TUSHBAI	ACCOUNTING	7,784
KBKB LLC	ACCOUNTING	20,250
RICHARD PEELO	MEDICARE COST REPORT	3,250
PERSONNEL PLANNING	UNEMPLOYMENT CONSULT	600
ADVANTAGE BENEFITS	501A CONSULTANT	1,512
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 65,279

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,000
Unemployment Compensation Insurance	9,873
FICA Taxes	254,344
Employee Health Insurance	224,337
Employee Meals	12,483
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	550
EMPLOYEE PHYSICAL EXAMS	5,234
PENSION/PROFIT SHARING PLANS (CVA)	(3,062)
TOTAL (agree to Schedule V, line 22, col.8)	$ 545,759

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	11,700
Health Care Worker Background Check	266
(Indicate # of checks performed 8)	
Patient Background Checks 33	330
TRUST/FRANCHISE/CONTRIB/ETC	75
MARKETING/ADV/PROMO	41,707
LICENSES/DUES/SUBSCRIPTIONS	7,260
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(75)
Less: Public Relations Expense	(0)
Non-allowable advertising	(25,746)
Yellow page advertising	(15,961)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,536

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 NURSING & REHAB CENTER LLC
LEGAL EXPENSES
12/31/2018

DATE	FIRM	INVOICE #	PURPOSE	COST	TOTAL
2.18	MCCABE KIRSHNER		ABK CONSULTING - 2567 REPORT	133.50	
					133.50
2.18	RIEFF SCHRAMM KANTER GUTTMAN		REAL ESTATE TAX ABATEMENT-FILING FEE	260.00	
2.18	RIEFF SCHRAMM KANTER GUTTMAN		REAL ESTATE TAX ABATEMENT-FILING FEE	260.00	
12.18	RIEFF SCHRAMM KANTER GUTTMAN		REAL ESTATE TAX ABATEMENT-FILING FEE	260.00	
					913.50
3.18	MILLER COOPER & CO		EMPLOYEE RECRUITMENT SERVICES	2,988.26	
3.18	MILLER COOPER & CO		EMPLOYEE RECRUITMENT SERVICES	1,791.25	
					4,779.51
6.18	MUCH SHELIST	486569	CORPORATE MATTERS	78.00	
9.18	MUCH SHELIST		CORPORATE MATTERS	350.00	
					428.00
				TOTAL	**6,254.51**
			DISALLOWED LEGAL TO PG 5A		(428.00)
					5,826.51

Facility Name & ID Number DOBSON PLAZA NURSING & REHAB CENTER LLC # 0051508 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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. $ **23,034** 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. $ **222,159**
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. $ **12,483** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

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