		FOR BHF USE			

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0051508

Facility Name: Dobson Plaza

Address: 120 Dodge Avenue (Number) Evanston (City) 60202 (Zip Code)

County: Cook

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

HFS ID Number:

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

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code ____
- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other ____
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other ____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) See Accountant's Report Attached	(Date)
	(Print Name and Title)	
	(Firm Name & Address) Mendel Schneider & Associates CPA PC 4051 Old Orchard Rd Skokie Illinois 60076	
	(Telephone) 847-933-1274	Fax # 847-933-1283

In the event there are further questions about this report, please contact:
Name: Mendel Schneider Telephone Number: 847-933-1274
Email Address:

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,502	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,502	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,300	750	3,553	5,603	8
9	SNF/PED					9
10	ICF	11,593	6,660		18,253	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,893	7,410	3,553	23,856	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.20%

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 07/01/11

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 3,553

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 Fiscal Year: 12/31

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

Facility Name & ID Number: Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	240,679	19,320		259,999		259,999		259,999			1
2	Food Purchase		168,783		168,783	(12,000)	156,783	(822)	155,961			2
3	Housekeeping	82,991	53,033	15,248	151,272		151,272		151,272			3
4	Laundry	42,117	9,515		51,632		51,632		51,632			4
5	Heat and Other Utilities			68,120	68,120		68,120		68,120			5
6	Maintenance	86,000		78,126	164,126		164,126		164,126			6
7	Other (specify):*											7
8	**TOTAL General Services**	451,787	250,651	161,494	863,932	(12,000)	851,932	(822)	851,110			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,143,444	203,965	72,742	2,420,151		2,420,151		2,420,151			10
10a	Therapy	297,398			297,398		297,398		297,398			10a
11	Activities	111,890	9,502		121,392		121,392		121,392			11
12	Social Services	40,477			40,477		40,477		40,477			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,593,209	213,467	96,742	2,903,418		2,903,418		2,903,418			16
	C. General Administration											
17	Administrative	210,643		198,490	409,133		409,133		409,133			17
18	Directors Fees											18
19	Professional Services			29,912	29,912		29,912		29,912			19
20	Dues, Fees, Subscriptions & Promotions			59,228	59,228		59,228	(40,464)	18,764			20
21	Clerical & General Office Expenses	396,898	44,665	62,232	503,795		503,795	235	504,030			21
22	Employee Benefits & Payroll Taxes			615,348	615,348	12,000	627,348		627,348			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,219	1,219		1,219		1,219			24
25	Other Admin. Staff Transportation			4,255	4,255		4,255	(4,255)				25
26	Insurance-Prop.Liab.Malpractice			216,983	216,983		216,983		216,983			26
27	Other (specify):*											27
28	**TOTAL General Administration**	607,541	44,665	1,187,667	1,839,873	12,000	1,851,873	(44,484)	1,807,389			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,652,537	508,783	1,445,903	5,607,223		5,607,223	(45,306)	5,561,917			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 Number Dobson Plaza #0051508 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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			3,352	3,352		3,352	151,046	154,398			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							261,142	261,142			32
33	Real Estate Taxes			475,410	475,410		475,410	34,096	509,506			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):* Bad Debt			64,370	64,370		64,370	(64,370)				36
37	**TOTAL Ownership**			1,563,132	1,563,132		1,563,132	(638,086)	925,046			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			118,774	118,774		118,774		118,774			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,918	172,918		172,918		172,918			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			291,692	291,692		291,692		291,692			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,652,537	508,783	3,300,727	7,462,047		7,462,047	(683,392)	6,778,655			45

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(88,636)	30		9
10	Interest and Other Investment Income	(9,272)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(822)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,255)	25		16
17	Non-Care Related Fees				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	(64,370)	36		24
25	Fund Raising, Advertising and Promotional	(40,464)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (207,819)		$	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)	(475,573)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (475,573)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (683,392)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Dobson Plaza

ID# 0051508

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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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	0		49

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(822)	0	0	0	0	0	0	0	0	0	0	(822)	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**	(822)	0	0	0	0	0	0	0	0	0	0	(822)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(40,464)	0	0	0	0	0	0	0	0	0	0	(40,464)	20
21	Clerical & General Office Expenses	0	235	0	0	0	0	0	0	0	0	0	235	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	(4,255)	0	0	0	0	0	0	0	0	0	0	(4,255)	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**	(44,719)	235	0	0	0	0	0	0	0	0	0	(44,484)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(45,541)	235	0	0	0	0	0	0	0	0	0	(45,306)	29

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(88,636)	239,682	0	0	0	0	0	0	0	0	0	151,046	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,272)	270,414	0	0	0	0	0	0	0	0	0	261,142	32
33	Real Estate Taxes	0	34,096	0	0	0	0	0	0	0	0	0	34,096	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):*	(64,370)	0	0	0	0	0	0	0	0	0	0	(64,370)	36
37	**TOTAL Ownership**	(162,278)	(475,808)	0	0	0	0	0	0	0	0	0	(638,086)	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)**	(207,819)	(475,573)	0	0	0	0	0	0	0	0	0	(683,392)	45

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Dobson Plaza Inc	Chicago	Bldg Rental
Arthur Kohn	1					

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	100.00%	$	$ (1,020,000)	1
2	V	30	Depreciation				239,682	239,682	2
3	V	32	Interest				270,414	270,414	3
4	V	21	Office				235	235	4
5	V	33	Real Estate Tax				34,096	34,096	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			$ 544,427	$ * (475,573)	14

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Charlotte Kohn		Adm	99.00	909,212	33	55.00	Salary	$ 180,000	17-1	1
2	Barak Kohn		Adm Cons		11,125	18	60.00	Salary	30,643	17-1	2
3	Rebecca Kohn		Cons		53,400	6	50.00	Salary	56,400	21-1	3
4	Cynthia Kohn		Bkkpg		57,000	4	13.00	Salary	49,004	21-1	4
5	Arthur Kohn		Mgmt	1.00		40	100.00	Mgmt Fees	198,490	17-3	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 514,537		13

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

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Fifth Third Bank		X	Mortgage	$32,835.00	12/5/19	$ 4,500,000	$ 4,220,309	12/5/29	Prime	$ 270,414	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$32,835.00		$ 4,500,000	$ 4,220,309			$ 270,414	9
	B. Non-Facility Related*											
10	Interest Income										(9,272)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,272)	14
15	TOTALS (line 9+line14)						$ 4,500,000	$ 4,220,309			$ 261,142	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 # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	315,151	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.)	$	410,277	2
3. Under or (over) accrual (line 2 minus line 1).	$	95,126	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	414,380	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.	$	509,506	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	231,211	8
	2016	285,279	9
	2017	300,851	10
	2018	308,971	11
	2019	410,277	12

Line 4: 410277 x 1.01

Line	FOR BHF USE ONLY		Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dobson Plaza 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 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	10-25-113-043-0000		$ 409,683.43	$ 409,683.43
2.	10-25-220-015-0000		$ 593.16	$ 593.16
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 410,276.59	$ 410,276.59

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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? [X] (a) Own the Facility [ ] (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? [X] (a) Own the Equipment [ ] (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).

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	Facility	18,167	1966	$ 80,509	1
2					2
3	TOTALS	18,167		$ 80,509	3

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	58		1966	1966	$ 251,171	$	35	$	$	$ 251,171	4
5	37			1987	930,705	26,987	40	23,268	(3,719)	777,037	5
6	2			1971	11,147		35			11,147	6
7											7
8											8
	Improvement Type**										
9	Electrical & Plumbing			1976	1,027		8			1,027	9
10	Sprinkler System			1982	9,921		15			9,921	10
11	Nursing Office			1982	891		15			891	11
12	Renovate Nursing Station			1986							12
13	Landscaping			1988	6,905		10			6,905	13
14	Sewer			1988	5,650		25			5,650	14
15	Fencing			1988	1,878		15			1,878	15
16	Paving			1988							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			5,600	24
25	Remodelling of Ancillary Areas			1997	516,118	16,180	40	13,374	(2,806)	320,976	25
26	Canopy Sign			1999	8,000	205	39	205		4,382	26
27	Elevator Repair			1999							27
28	Fire Dampers/Air Intakes			2000	10,515	382	27.5	382		7,879	28
29	Elevator Upgrade-Air Intakes			2000	18,221	1,028	27.5	1,028		20,277	29
30	Elevator Upgrade			2001	18,221	690	27.5	690		13,656	30
31	Carpeting			2001	23,914		10			23,914	31
32	Heat Exchanger/Fire Suppresion System			2003	11,572	421	27.5	421		7,464	32
33	Hydraulic Elevator Pump			2006	10,772	392	27.5	392		5,798	33
34	Bathroom Fixtures/Lighting/Carpentry/Rails/Wallpaper			2006	29,463	1,071	27.5	1,071		15,636	34
35	Nursing Station/Bathrooms/Plumbing/Flooring/Roof			2007	53,627	1,950	27.5	1,950		26,405	35
36	Beauty Shop Drywall/Cabintry/Plumbing/Tile			2007	7,287	264	27.5	264		3,430	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Retardent Cement	2008	$ 8,404	$ 306	27.5	$ 306	$	$ 3,943	37
38	PT,AAD,Dayrooms-Drywall,Flooring,Studs,Joist	2008	19,380	705	27.5	705		9,018	38
39	Bathrooms-Tile,Floor,Drywall,Paint,Paper	2008	15,425	561	27.5	561		7,090	39
40	Repipe Kitchen water lines	2008	2,065	75	27.5	75		955	40
41	Flood Service Counter/Cabinet/Flooring	2008	3,015	109	27.5	109		1,369	41
42	Lower Level Bathroom Project	2008	26,300	956	27.5	956		11,607	42
43	Lower Level Nurses Station	2008	12,500	455	27.5	455		5,517	43
44	Upper Roof Replacement	2008	18,500	673	27.5	673		8,160	44
45	Carpeting	2008	11,259		10			11,259	45
46	Driveway Parking Lot	2008	18,807	1,254	15	1,254		15,674	46
47	Therapy Room Wall/Shelving/Carpentry/Doors	2009	5,530	201	27.5	201		2,395	47
48	2nd Floor Roofs/5 Ton A/C Condenser	2009	11,025	443	27.5	443		5,209	48
49	Security system/Cables/Wanderguard Wiring	2009	5,671	206	27.5	206		2,402	49
50	Carpentry/recessed lighting/Wiring 28 Outlets	2009	7,975	290	27.5	290		3,275	50
51	Sump Pump Motor & Pipelines	2009	3,700	135	27.5	135		1,526	51
52	Ceramic Floor/Carpentry/Clloset/Intercom/Cable	2009	2,919	108	27.5	108		1,193	52
53	Carpeting/Window Treatments	2009	7,403		10			7,403	53
54	Outlets/Cable wall Mounts	2010	8,730	317	27.5	317		3,421	54
55	Nurses Station Built-Ins/Drywall	2010	5,011	215	27.5	215		2,123	55
56	Delayed Elevator Egress Locks	2010	3,868	141	27.5	141		1,498	56
57	Wallpaper/Carpeting/Cove Base/Base Boards	2010	12,741		10	638	638	12,741	57
58	Sump Pump	2010	2,600	281	27.5	281		2,869	58
59	Weil Pump	2011	5,119		10	512	512	4,864	59
60	2nd Fl Nursing Station/Carpentry/Built Ins/Closet/Rails	2011	3,015	205	27.5	205		1,990	60
61	1st Floor Nursing Station Sockets/Lighting/Built In Kitchen Cabin								61
62	Bathroom Work/Library duc & Seal Windows/1st fl Bathroom De								62
63	New Dry Wall/Soffits/Concrete	2012	48,520	1,845	27.5	1,845		15,606	63
64									64
65	A/C forDining Room	2012	3,120	113	27.5	113		956	65
66	Wiring	2014	5,597	203	27.5	203		1,349	66
67	Security System Upgrades	2015	3,100	178	15	178		2,397	67
68	Elevator Retractable Ladder & wiring	2015	4,026	146	27.5	146		773	68
69	2nd Fl Corridor & Dayroom Flooring	2015	18,961	690	27.5	690		3,474	69
70	TOTAL (lines 4 thru 69)		$ 2,510,026	$ 60,381		$ 55,006	$ (5,375)	$ 1,946,835	70

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 60,381		$ 55,006	$ (5,375)	$ 1,946,835	1
2	Hot Water Tank	2016	10,253	373	27.5	373		1,756	2
3	1st Floor Corridor Carpeting	2016	3,694	134	27.5	134		631	3
4	Elevator Main Control Valve	2016	6,500	236	27.5	236		1,072	4
5	Nurses Station	2017	14,300	520	27.5	520		2,058	5
6	Kohler Generator	2017	50,000	1,818	27.5	1,818		7,045	6
7	2nd Floor Dayroom PVT Flooring & Cove Base	2017	5,424	197	27.5	197		747	7
8	3rd Floor Corridor Carpeting	2017	5,221	190	27.5	190		689	8
9	South Roofing Cooling Heater Unit	2017	14,915	542	27.5	542		1,874	9
10	Shunt Trip Unit in Elevator	2017	5,643	205	27.5	205		641	10
11	2019 Improvements:								11
12	1st Floor Day Room Expansion and Renovation								12
13	Renovation of Office and Front Lobby Area Including Entrances								13
14	Expansion of Basement Physical Therapy Space and Conference								14
15	Room Addition								15
16	Renovation of 2 Resident Rooms on First Floor	2019	1,618,300	153,753	27.5	58,847	(94,906)	117,694	16
17	Improvements-Contracted Total	2019	33,891		15	2,259	2,259	3,389	17
18	New Sign(TFA Signs),Paneling the Connection Room								18
19	(Hanna Z Interiors),Laminated Lobby Paneling, Carpet								19
20	Tile for Corridor Ares								20
21	Marco Welding-Wrought Iron Fence	2020	8,500	8,500	15	567	(7,933)	567	21
22	Stanko Flooring-First Floor Corridor	2020	7,000	7,000	15	467	(6,533)	467	22
23	Sign, Electrical Repair-Contracted Total	2020	30,429	2,029	15	2,029		2,029	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)		$ 4,324,096	$ 235,878		$ 123,390	$ (112,488)	$ 2,087,494	34

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 173,515	$ 3,805	$ 17,937	$ 14,132	10	$ 98,404	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 173,515	$ 3,805	$ 17,937	$ 14,132		$ 98,404	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	Facility	17 Acura MDX	2016	$ 65,357	$ 3,351	$ 13,071	$ 9,720	5	$ 57,130	76
77										77
78										78
79										79
80	TOTALS			$ 65,357	$ 3,351	$ 13,071	$ 9,720		$ 57,130	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)	$ 4,643,477	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 243,034	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 154,398	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (88,636)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,243,028	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
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.	/2021	$
13.	/2022	$
14.	/2023	$

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

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

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				118,774		118,774	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$ 118,774		$ 118,774	14

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 508,123	$ 1,798,740	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,044,357	1,044,357	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	155,468	155,468	6
7	Other Prepaid Expenses	171,580	188,584	7
8	Accounts Receivable (owners or related parties)		784,085	8
9	Other(specify): Due from Others	1,840,001	1,840,001	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,719,529	$ 5,811,235	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		2,406,798	15
16	Equipment, at Historical Cost	65,357	296,951	16
17	Accumulated Depreciation (book methods)	(27,313)	(2,744,464)	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): 501K Life Contracts	318,771	318,771	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 356,815	$ 2,440,846	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,076,344	$ 8,252,081	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 196,114	$ 196,114	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,678	53,678	28
29	Short-Term Notes Payable	35,479	35,479	29
30	Accrued Salaries Payable	204,632	204,632	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,263	16,263	31
32	Accrued Real Estate Taxes(Sch.IX-B)		414,380	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	PPP Loan	747,528	747,528	36
37	Accd Mgmt Fees	368,155	368,155	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,621,849	$ 2,036,229	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,220,309	40
41	Bonds Payable			41
42	Deferred Compensation	1,123,621	1,123,621	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,123,621	$ 5,343,930	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,745,470	$ 7,380,159	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,330,874	$ 871,922	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,076,344	$ 8,252,081	48

*(See instructions.)

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,158,347	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,158,347	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	295,972	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	(123,445)	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)**	$ 172,527	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)**	$ 1,330,874	24 *

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

Facility Name & ID Number Dobson Plaza # 0051508 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 6,992,241	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,992,241	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,520	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,520	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Stimulus Income	758,258	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 758,258	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,758,019	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	863,932	31
32	Health Care	2,903,418	32
33	General Administration	1,839,873	33
	B. Capital Expense		
34	Ownership	1,563,132	34
	C. Ancillary Expense		
35	Special Cost Centers	118,774	35
36	Provider Participation Fee	172,918	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,462,047	40
41	**Income before Income Taxes (line 30 minus line 40)****	295,972	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 295,972	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,313,861	44
45	Private Pay - Net Inpatient Revenue	1,904,268	45
46	Medicare - Net Inpatient Revenue	2,774,112	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,992,241	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No,CashBas 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.

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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	1,937	2,201	$ 112,521	$ 51.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,841	28,387	963,604	33.95	3
4	Licensed Practical Nurses	3,285	3,977	106,782	26.85	4
5	CNAs & Orderlies	55,233	61,584	960,537	15.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,533	5,613	297,398	52.98	8
9	Activity Director	2,022	2,193	41,822	19.07	9
10	Activity Assistants	4,037	4,057	70,068	17.27	10
11	Social Service Workers	1,632	1,855	40,477	21.82	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,080	75,000	36.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,964	12,238	165,679	13.54	15
16	Dishwashers					16
17	Maintenance Workers	4,134	4,806	86,000	17.89	17
18	Housekeepers	4,528	5,160	82,991	16.08	18
19	Laundry	2,607	2,919	42,117	14.43	19
20	Administrator					20
21	Assistant Administrator	2,080	2,080	180,000	86.54	21
22	Other Administrative	2,080	2,080	30,643	14.73	22
23	Office Manager					23
24	Clerical	9,863	10,332	276,698	26.78	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	2,080	2,080	120,200	57.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,696	153,642	$ 3,652,537 *	$ 23.77	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		$		35
36	Medical Director	Monthly	24,000	9-3	36
37	Medical Records Consultant	50	3,121	10-3	37
38	Nurse Consultant	35	1,898	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	85	$ 29,019		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,250	67,723	10-3	52
53	TOTAL (lines 50 - 52)	2,250	$ 67,723		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charlotte Kohn	Adm	99	$ 180,000
Barak Kohn	Other Adm	0	30,643
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 210,643

B. Administrative - Other

Description	Amount
Arthur Kohn-Mgmt Fees	$ 198,490
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 198,490

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider CPA	Accounting	$ 18,000
Richard Peelo	Accounting	3,250
Myron Tushbai	Accounting	6,104
Personnel Planners	UC Tax	948
Advantage	Benefits Cons	880
Reid Shrank & Kanter	Legal	730
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 29,912

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,673
Unemployment Compensation Insurance	11,500
FICA Taxes	243,601
Employee Health Insurance	293,574
Employee Meals	12,000
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 627,348

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,704
(Indicate # of checks performed)	
Patient Background Checks	
License-City of Evanston	13,080
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,764

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Various	1,219
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,219

**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? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,000** Line **10**

(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 #0008136 7/1/2011

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **172,918**
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. $ **12,000** Has any meal income been offset against related costs? **0** 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? **0**
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period. $

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.