



Facility Name & ID Number DOBSON PLAZA

# 0008136 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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	35,405	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,209	11,724	2,890	31,823	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,209	11,724	2,890	31,823	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.88%**

**D. How many bed-hold days during this year were paid by the Department?**  
0 (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)**  
NONE

**F. Does the facility maintain a daily midnight census?** YES

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**  
YES  NO

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**  
YES  NO

**I. On what date did you start providing long term care at this location?**  
Date started 10/15/66

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date \_\_\_\_\_ NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 97 and days of care provided 1,624

Medicare Intermediary MUTUAL OF OMAHA

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **DOBSON PLAZA** # **0008136** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	67,433	14,519	49,218	131,170		131,170	0	131,170		1
2	Food Purchase		130,967		130,967	(9,198)	121,769	(1,014)	120,755		2
3	Housekeeping	15,836	22,101	0	37,937		37,937	0	37,937		3
4	Laundry	60,037	9,864	254	70,155	0	70,155	0	70,155		4
5	Heat and Other Utilities			88,443	88,443		88,443	0	88,443		5
6	Maintenance	58,307	8,004	36,472	102,783		102,783	(3,648)	99,135		6
7	Other (specify):*			6,978	6,978		6,978	0	6,978		7
8	<b>TOTAL General Services</b>	<b>201,613</b>	<b>185,455</b>	<b>181,365</b>	<b>568,433</b>	<b>(9,198)</b>	<b>559,235</b>	<b>(4,662)</b>	<b>554,573</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		5,000	5,000		5,000	0	5,000		9
10	Nursing and Medical Records	1,589,547	70,274	6,148	1,665,969		1,665,969	0	1,665,969		10
10a	Therapy	18,662		18,569	37,231		37,231	0	37,231		10a
11	Activities	87,899	12,341	0	100,240		100,240	0	100,240		11
12	Social Services	23,885		3,840	27,725		27,725	0	27,725		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			75	75		75	0	75		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,719,993</b>	<b>82,615</b>	<b>33,632</b>	<b>1,836,240</b>	<b>0</b>	<b>1,836,240</b>	<b>0</b>	<b>1,836,240</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	139,150		0	139,150		139,150	0	139,150		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			46,255	46,255		46,255	0	46,255		19
20	Dues, Fees, Subscriptions & Promotions			62,724	62,724		62,724	(54,163)	8,561		20
21	Clerical & General Office Expenses	82,264	15,729	20,345	118,338		118,338	(4,346)	113,992		21
22	Employee Benefits & Payroll Taxes			393,185	393,185	9,198	402,383	0	402,383		22
23	Inservice Training & Education			465	465		465	0	465		23
24	Travel and Seminar			0	0		0	0	0		24
25	Other Admin. Staff Transportation			7,358	7,358		7,358	(127)	7,231		25
26	Insurance-Prop.Liab.Malpractice			106,799	106,799		106,799	0	106,799		26
27	Other (specify):*			0	0		0	0	0		27
28	<b>TOTAL General Administration</b>	<b>221,414</b>	<b>15,729</b>	<b>637,131</b>	<b>874,274</b>	<b>9,198</b>	<b>883,472</b>	<b>(58,636)</b>	<b>824,836</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,143,020</b>	<b>283,799</b>	<b>852,128</b>	<b>3,278,947</b>	<b>0</b>	<b>3,278,947</b>	<b>(63,298)</b>	<b>3,215,649</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	49,218
	REPAIRS & MAINTENANCE	0
		0
		49,218
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	254
		0
		254
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	26,669
	ELECTRICITY	26,868
	WATER	34,906
	CABLE TV - LOBBY	0
		0
		88,443
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	2,526
	PAINTING & DECORATING	12,202
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,377
	ELEVATOR MAINTENANCE & REPAIR	4,350
	OUTSIDE LABOR	182
	EXTERMINATING SERVICE	2,496
	FIRE SERVICE	5,339
		0
		0
		0
		0
		36,472
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	6,978
	SECURITY SERVICE	0
		0
		0
		6,978
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	5,000
		5,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,224
	PHARMACY CONSULTANT XVIII B 39-2	1,924
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		6,148
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	18,569
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		18,569
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
	CLERGY	0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,840
		0
		3,840
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	75
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
<b>18</b>	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	7,178
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	39,077
		0
		46,255
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	16,225
	EMPLOYEE WANT ADS XIX F	519
	CONTRIBUTIONS VI 20 XIX F	750
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	6,782
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	36,863
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	325
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	120
	PATIENT BACKGROUND CHECKS XIX F	1,140
		62,724
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	547
	EQUIPMENT REPAIR & MAINTENANCE	2,618
	OUTSIDE CLERICAL SERVICES	449
	PENALTIES / OVERDRAFT CHARGES VI 18	4,346
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,385
	MESSENGER SERVICE	0
		0
		20,345

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	163,946
	UNEMPLOYMENT COMPENSATION XIX D	13,125
	WORKERS COMPENSATION INSURANC XIX D	50,999
	HOSPITALIZATION INSURANCE XIX D	157,886
	EMPLOYEE BENEFITS - OTHER XIX D	1,287
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	501 PLAN EXPENSE XIX D	5,942
	CHICAGO HEAD TAX XIX D	0
		0
		393,185
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	465
		465
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	7,231
	AUTO EXPENSES -OTHER	127
		7,358
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	106,799
		106,799
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

852,128

**DOBSON PLAZA  
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
12/31/2006**

TOTAL FOOD PURCHASE	130,967	PATIENT MEALS	95469
LESS SALES TAX	(1,014)	ADD EMPLOYEE MEALS	7300
-----		-----	
NET FOOD	129,953	TOTAL MEALS/YEAR	102769
TOTAL PATIENT CENSUS	31,823	NET FOOD	129953
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	102769
-----		-----	
TOTAL PATIENT MEALS	95469	COST PER MEAL	1.26
		TIME EMPLOYEE MEALS	7300
ADD # EMPLOYEE MEALS/DAY	20	EMPLOYEE MEAL RECLASSIFICATION	<b>9198</b>
TIME # DAYS	365		=====
-----		=====	
TOTAL EMPLOYEE MEALS	7300		

**DOBSON PLAZA, INC,  
TRANSPORTATION - STAFF  
2006**

ACCT #18370 -508003

	NAME	DEPARTMENT	PURPOSE	MISC	AUTO ALLOW J GRODETZ
6-Jan	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
6-Jan	FIRST CARD	FACILITY	activities	18	
6-Feb	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
6-Feb	CHASE CARD	FACILITY	activities	293.68	
6-Feb	SEC OF STATE	FACILITY	License Plate Stickers	156	
6-Mar	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
6-Mar	CHASE CARD	FACILITY	activities	521.34	
6-Apr	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
6-Apr	CHASE CARD	FACILITY	activities	605.22	
6-May	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
6-May	CHASE CARD	FACILITY	activities	203.65	
6-Jun	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
5-Jun	CHASE CARD	FACILITY	activities	135.05	
6-Jul	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
6-Jul	CHASE CARD	FACILITY	activities	59.01	
6-Aug	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
6-Aug	CHASE CARD	FACILITY	activities	242.62	
6-Aug	PETTY CASH	FACILITY	activities	16.65	
6-Sep	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
6-Sep	CHASE CARD	FACILITY	activities	265	
6-Oct	CHASE CARD	FACILITY	activities	50	
6-Oct	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
6-Nov	SEC OF STATE	FACILITY	STATE LICENSE	80	
6-Nov	PETTY CASH	FACILITY	activities	4.75	
6-Nov	CITY OF EVANSTON	FACILITY	CITY LICENSE	60	
6-Nov	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
6-Dec	CHASE CARD	FACILITY	activities	226.38	
6-Dec	CHASE CARD	FACILITY	activities	72.87	
6-Dec	SAM'S CLUB	FACILITY	activities	20.83	
6-Dec	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
-----				-----	-----
TOTAL				<b>3031.05</b>	<b>4200.04</b>

**TOTAL STAFF TRANSPORTATION:**

**7231.09**

=====

Facility Name & ID Number **DOBSON PLAZA**

#0008136

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			68,195	68,195		68,195	8,242	76,437			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			334,145	334,145		334,145	(85,954)	248,191			32
33	Real Estate Taxes			124,438	124,438		124,438	0	124,438			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			3,051	3,051		3,051	0	3,051			35
36	Other (specify):*				0		0	0	0			36
37	<b>TOTAL Ownership</b>			529,829	529,829	0	529,829	(77,712)	452,117			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		77,822	32,424	110,246		110,246	0	110,246			39
40	Barber and Beauty Shops			1,593	1,593		1,593	0	1,593			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			53,108	53,108		53,108	0	53,108			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	77,822	87,125	164,947	0	164,947	0	164,947			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,143,020	361,621	1,469,082	3,973,723	0	3,973,723	(141,010)	3,832,713			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**

# **0008136**

Report Period Beginning:

**01/01/2006**

Ending:

**12/31/2006**

**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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	8,242	30		9
10	Interest and Other Investment Income	(85,550)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,014)	2		13
14	Non-Care Related Interest	(404)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(127)	25		16
17	Non-Care Related Fees	(325)	20		17
18	Fines and Penalties	(4,346)	21		18
19	Entertainment				19
20	Contributions	(750)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,225)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(36,863)	20		28
29	Other-Attach Schedule <u>DEFERRED MAINTENANCE</u>	(3,648)	6		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (141,010)		\$ 0	30

<b>BHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	0		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 0		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (141,010)		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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

DOBSON PLAZA

ID# 0008136

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (3,648)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(3,648)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA# 0008136 Report Period Beginning:

01/01/2006

Ending: 12/31/2006

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,014)	0	0	0	0	0	0	0	0	0	0	(1,014)	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	(3,648)	0	0	0	0	0	0	0	0	0	0	(3,648)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,662)</b>	0	0	0	0	0	0	0	0	0	0	<b>(4,662)</b>	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	0	0	0	0	0	0	0	0	0	0	<b>0</b>	16
	<b>C. General Administration</b>													
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	(54,163)	0	0	0	0	0	0	0	0	0	0	(54,163)	20
21	Clerical & General Office Expenses	(4,346)	0	0	0	0	0	0	0	0	0	0	(4,346)	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	(127)	0	0	0	0	0	0	0	0	0	0	(127)	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	<b>TOTAL General Administration</b>	<b>(58,636)</b>	0	0	0	0	0	0	0	0	0	0	<b>(58,636)</b>	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(63,298)</b>	0	0	0	0	0	0	0	0	0	0	<b>(63,298)</b>	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA

# 0008136

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,242	0	0	0	0	0	0	0	0	0	0	8,242	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(85,954)	0	0	0	0	0	0	0	0	0	0	(85,954)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>(77,712)</b>	<b>0</b>	<b>(77,712)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(141,010)</b>	<b>0</b>	<b>(141,010)</b>	<b>45</b>									

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

**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.**  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

DOBSON PLAZA

#

0008136

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CHARLOTTE KOHN	ADMINISTRATOR	SUPERVISION	0.00	570,373	27	45.00	SALARY	\$ 62,572	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 62,572		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

# 0008136 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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**

# **0008136**

Report Period Beginning:

**01/01/2006**

Ending:

**12/31/2006**

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	MB FINANCIAL		X	MORTGAGE	\$39,650.00	12/16/04	\$ 5,500,000	\$ 5,176,237	12/16/09	6.0000	\$ 319,821	1								
2	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS		12/16/04	17,760	10,656			3,552	2								
3												3								
4	NISSAN		X	AUTO LOAN	\$549.87	03/04/03	29,883	8,061	02/04/08	3.9700	431	4								
5	LEXUS		X	AUTO LOAN	\$606.41	09/30/03	27,987	4,528	09/30/07		176	5								
<b>Working Capital</b>																				
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$6,782.30	06/01/05	77,512	0	06/01/06	5.0000	2,261	6								
7	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$9,226.40	06/01/06	110,717	64,585	06/01/07		2,917	7								
8	NATIONAL REPUBLIC BK		X	WORKING CAPITAL	2333.00+INT	04/01/03	140,000	37,333		PRIME+	4,583	8								
9	TOTAL Facility Related				\$56,814.98		\$ 5,903,859	\$ 5,301,400			\$ 333,741	9								
<b>B. Non-Facility Related*</b>																				
10	NATIONAL REPUBLIC BK		X	INTEREST ON OVERDRAFTS							404	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 404	14								
15	TOTALS (line 9+line14)						\$ 5,903,859	\$ 5,301,400			\$ 334,145	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$   N/A                        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.)

**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.

1. Real Estate Tax accrual used on 2005 report.		\$	<b>119,680</b>	<b>1</b>
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.)		\$	<b>121,551</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>1,871</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>122,770</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ <u>203</u> For <u>1999</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>(203)</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>124,438</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2001</b>	<b>112,367</b>	<b>8</b>
	<b>2002</b>	<b>114,247</b>	<b>9</b>
	<b>2003</b>	<b>117,516</b>	<b>10</b>
	<b>2004</b>	<b>118,491</b>	<b>11</b>
	<b>2005</b>	<b>121,551</b>	<b>12</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.**

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME DOBSON PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0008136

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-25-113-043-0000</u>	<u>NURSING HOME</u>	\$ <u>119,421.78</u>	\$ <u>119,421.78</u>
2. <u>10-25-220-015-0000</u>	<u>NURSING HOME</u>	\$ <u>2,129.35</u>	\$ <u>2,129.35</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>121,551.13</u>	\$ <u>121,551.13</u>

**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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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

# 0008136

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**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  (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  (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  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	<u>NURSING HOME</u>	<u>7,728</u>	<u>1966</u>	<u>\$ 80,506</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<u>7,728</u>		<u>\$ 80,506</u>	<u>3</u>

Facility Name &amp; ID Number DOBSON PLAZA

# 0008136

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	58	1966	1966	\$ 251,171	\$	35	\$	\$	\$ 251,171	4
5	33		1987	930,705	38,099	40	23,268	(14,831)	474,553	5
6	2		1971	11,147		8-12			11,147	6
7	4		1987	64,011		30	1,067	1,067	6,402	7
8										8
	<b>Improvement Type**</b>									
9	ELECTRICAL & PLUMBING		1976	1,027		8			1,027	9
10	SPRINKLER SYSTEM		1982	9,921		15			9,921	10
11	NURSING OFFICE		1982	891		15			891	11
12	RENOVATE NURSING STATION		1986	5,223		20	261	261	4,980	12
13	LANDSCAPING		1988	6,905		10			6,905	13
14	LAND IMPROVEMENTS - SEWER		1988	5,650		25	226	226	4,030	14
15	LAND IMPROVEMENTS - FENCING		1988	1,878		15			1,878	15
16	LAND IMPROVEMENTS - PAVING		1988	12,335		20	617	617	11,003	16
17	OUTSIDE SIGN		1988	2,473		12			2,473	17
18	SPRINKLER SYSTEM		1988	42,241		25	1,690	1,690	30,138	18
19	HEATING, VENTILATION, & A/C		1988	48,620		20	2,431	2,431	43,353	19
20	PLUMBING COMPOSITE		1988	63,062		25	2,522	2,522	45,479	20
21	ELECTRICAL WIRING		1988	115,484		20	5,774	5,774	102,970	21
22	BRICK-ENCLOSED GENERATOR		1989	1,375		25	55	55	908	22
23	FENCE - GENERATOR		1989	480		15			480	23
24	CATCH BASIN		1989	5,000		10			5,000	24
25	REMODELLING OF ANCILLARY AREAS		1997	534,985	16,180	40	13,374	(2,806)	133,740	25
26	CANOPY SIGN		1999	8,000	205	39	205		1,512	26
27	ELEVATOR REPAIR		1999	1,990	51	39	51		368	27
28	FIRE DAMPERS / AIR INTAKES		2000	10,515	382	27.5	382		2,531	28
29	ELEVATOR UPGRADE / AIR INTAKES		2000	28,259	1,028	27.5	1,028		6,297	29
30	ELEVATOR UPGRADE		2001	18,977	690	27.5	690		3,996	30
31	CARPETING		2001	25,597	1,251	10	2,560	1,309	14,080	31
32	HEAT EXCHANGER / FIRE SUPPRESSION SYSTEM		2003	11,572	421	27.5	421		1,570	32
33	HYDRAULIC ELEVATOR PUMP		2006	10,772	310	27.5	310		310	33
34	BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER		2006	34,563	720	27.5	720		720	34
35										35
36										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.

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,264,829	\$ 59,337		\$ 57,652	\$ (1,685)	\$ 1,179,833	70

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

Facility Name & ID Number **DOBSON PLAZA**

# **0008136**

Report Period Beginning:

**01/01/2006**

Ending:

**12/31/2006**

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-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	\$ 23,682	\$ 683	\$ 2,390	\$ 1,707	8-10 YRS	\$ 12,514	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets	23,264			0	5-10 YRS	23,264	73
74					0			74
75	<b>TOTALS</b>	\$ 46,946	\$ 683	\$ 2,390	\$ 1,707		\$ 35,778	75

**D. Vehicle Depreciation (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,	'98 LEXUS	1998	\$ 68,441	\$ 1,775	\$ 1,775	\$ 0		\$ 8,875	76
77	ACTIVITIES, MAINT,	'95 JEEP	2001	19,087	1,775		(1,775)		19,087	77
78	& PURCHASING,	'03 NISSAN	2003	30,491	1,775	7,623	5,848		26,681	78
79	ETC	'01 LEXUS	2003	27,987	2,850	6,997	4,147		17,492	79
80	<b>TOTALS</b>			\$ 146,006	\$ 8,175	\$ 16,395	\$ 8,220		\$ 72,135	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)	\$ 2,538,287	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,195	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,437	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,242	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,287,746	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	<b>TOTALS</b>	\$	\$	\$	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: \_\_\_\_\_ \*

**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: \$ 3,051 Description: STORAGE

(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		\$	\$ 0	21

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. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

\* 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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 28,786	\$		\$ 28,786	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,138			3,138	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			500			500	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 prescripts				66,944		66,944	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					10,878		10,878	13
14	<b>TOTAL</b>			\$		\$ 32,424	\$ 77,822		\$ 110,246	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 &amp; ID Number DOBSON PLAZA

# 0008136

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,855,274	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	903,655		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	71,408		7
8	Accounts Receivable (owners or related parties)	1,949		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,832,286	\$ 0	10
	<b>B. Long-Term Assets</b>			
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	243,958		15
16	Equipment, at Historical Cost	195,425		16
17	Accumulated Depreciation (book methods)	(1,329,655)		17
18	Deferred Charges	10,656		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): <u>NY LIFE INSUR.CONTRACTS</u>	195,342		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,478,516	\$ 0	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,310,802	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 177,263	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,052		28
29	Short-Term Notes Payable	101,918		29
30	Accrued Salaries Payable	98,584		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,582		31
32	Accrued Real Estate Taxes(Sch.IX-B)	122,770		32
33	Accrued Interest Payable			33
34	Deferred Compensation	489,527		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>DEFERRED INCOME</u>	179,944		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,202,640	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	12,589		39
40	Mortgage Payable	5,176,237		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 5,188,826	\$ 0	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 6,391,466	\$ 0	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (2,080,664)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,310,802	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,979,883)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>IL REPLACEMENT TAX</b>	<b>(16,135)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,996,018)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>836,445</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(921,091)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(84,646)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,080,664)</b>	<b>24</b> *

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

**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**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,575,563	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,575,563	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	149,055	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 149,055	8
	<b>C. Other Operating Revenue</b>		
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	85,550	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 85,550	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,810,168	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	568,433	31
32	Health Care	1,836,240	32
33	General Administration	874,274	33
	<b>B. Capital Expense</b>		
34	Ownership	529,829	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	111,839	35
36	Provider Participation Fee	53,108	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,973,723	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	836,445	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 836,445	43

\* 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.

TAX RETURN PREPARED ON CASH BASIS

\*\*\* 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

# 0008136

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**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	1,527	1,719	\$ 60,681	\$ 35.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,741	22,755	652,501	28.68	3
4	Licensed Practical Nurses	6,170	6,589	150,860	22.90	4
5	CNAs & Orderlies	53,471	58,572	587,027	10.02	5
6	CNA Trainees					6
7	Licensed Therapist	679	699	18,662	26.70	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,199	2,520	40,932	16.24	9
10	Activity Assistants	3,280	3,446	46,967	13.63	10
11	Social Service Workers	940	949	23,885	25.17	11
12	Dietician					12
13	Food Service Supervisor	462	462	10,036	21.72	13
14	Head Cook	4,318	4,823	50,164	10.40	14
15	Cook Helpers/Assistants	1,075	1,075	7,233	6.73	15
16	Dishwashers					16
17	Maintenance Workers	5,917	6,824	58,307	8.54	17
18	Housekeepers	1,918	2,224	15,836	7.12	18
19	Laundry	7,746	8,519	60,037	7.05	19
20	Administrator	2,086	2,086	62,572	30.00	20
21	Assistant Administrator	2,085	2,246	76,578	34.10	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,373	4,787	82,264	17.18	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	1,990	2,207	23,823	10.79	31
32	Other Health C: <u>ADMISS'NS/QA</u>	4,224	4,224	114,655	27.14	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,201	136,726	\$ 2,143,020 *	\$ 15.67	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 49,218	1-3	35
36	Medical Director	O	5,000	9-3	36
37	Medical Records Consultant	N	4,224	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,924	10-3	39
40	Physical Therapy Consultant	L	18,569	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	3,840	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 82,775		49

**C. CONTRACT NURSES**

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



**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	PAINT/DECORATING	2003	\$ 9,666	3	\$ 1,611	\$ 3,222	\$ 3,222	\$ 1,611	\$	\$	\$	\$	\$
2	PAINT/DECORATING	2004	9,893	3		1,649	3,298	3,298	1,648				
3	PAINT/DECORATING	2005	4,833	3			806	1,611	1,611	805			
4	PAINT/DECORATING	2006	12,202	3				2,034	4,067	4,067	2,034		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$ 36,594		\$ 1,611	\$ 4,871	\$ 7,326	\$ 8,554	\$ 7,326	\$ 4,872	\$ 2,034	\$	\$

Facility Name &amp; ID Number DOBSON PLAZA

# 0008136

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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. \$ \_\_\_\_\_ 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 \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,108  
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. \$ 9,198 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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees