



Facility Name & ID Number DOBSON PLAZA

# 0008136 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	16,499	12,025	2,130	30,654	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,499	12,025	2,130	30,654	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.58%

D. How many bed-hold days during this year were paid by the Department? 3 (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 2,130

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **DOBSON PLAZA** # **0008136** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	102,559	16,099	46,330	164,988		164,988		164,988		1
2	Food Purchase		131,812		131,812	(9,636)	122,176	(788)	121,388		2
3	Housekeeping	19,059	23,135		42,194		42,194		42,194		3
4	Laundry	38,026	9,430		47,456		47,456		47,456		4
5	Heat and Other Utilities			96,338	96,338		96,338		96,338		5
6	Maintenance	52,449	4,666	29,776	86,891		86,891	3,103	89,994		6
7	Other (specify):*			6,219	6,219		6,219		6,219		7
8	<b>TOTAL General Services</b>	<b>212,093</b>	<b>185,142</b>	<b>178,663</b>	<b>575,898</b>	<b>(9,636)</b>	<b>566,262</b>	<b>2,315</b>	<b>568,577</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,645,977	65,604	5,690	1,717,271		1,717,271		1,717,271		10
10a	Therapy	20,826		31,501	52,327		52,327		52,327		10a
11	Activities	72,233	15,253		87,486		87,486		87,486		11
12	Social Services	23,603		3,840	27,443		27,443		27,443		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,762,639</b>	<b>80,857</b>	<b>47,031</b>	<b>1,890,527</b>		<b>1,890,527</b>		<b>1,890,527</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	136,663			136,663		136,663		136,663		17
18	Directors Fees										18
19	Professional Services			41,876	41,876		41,876	(2,250)	39,626		19
20	Dues, Fees, Subscriptions & Promotions			53,540	53,540		53,540	(44,257)	9,283		20
21	Clerical & General Office Expenses	115,387	12,487	25,302	153,176		153,176	(75)	153,101		21
22	Employee Benefits & Payroll Taxes			406,573	406,573	9,636	416,209		416,209		22
23	Inservice Training & Education			1,195	1,195		1,195		1,195		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			6,451	6,451		6,451	(128)	6,323		25
26	Insurance-Prop.Liab.Malpractice			113,911	113,911		113,911		113,911		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>252,050</b>	<b>12,487</b>	<b>648,848</b>	<b>913,385</b>	<b>9,636</b>	<b>923,021</b>	<b>(46,710)</b>	<b>876,311</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,226,782</b>	<b>278,486</b>	<b>874,542</b>	<b>3,379,810</b>		<b>3,379,810</b>	<b>(44,395)</b>	<b>3,335,415</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
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	46,206
	REPAIRS & MAINTENANCE	0
	OUTSIDE SERVICES	124
		46,330
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	30,427
	ELECTRICITY	31,820
	WATER	34,091
	CABLE TV - LOBBY	0
		0
		96,338
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	2,353
	PAINTING & DECORATING	4,223
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	11,426
	ELEVATOR MAINTENANCE & REPAIR	4,007
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,496
	FIRE SERVICE	5,271
		0
		0
		0
		0
		29,776
7	<b>OTHER</b>	
	SCAVENGER	6,069
	SECURITY SERVICE	150
		0
		0
		6,219
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	457
	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	1,009
	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
		5,690
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	31,501
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		31,501
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
	CLERGY	0
		0
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,840
		0
		3,840
13	<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	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	4,191
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	37,685
		0
		41,876
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,789
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	489
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	8,573
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	27,774
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	405
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	510
	PATIENT BACKGROUND CHECKS XIX F	0
		53,540
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	195
	EQUIPMENT REPAIR & MAINTENANCE	3,814
	OUTSIDE CLERICAL SERVICES	4,000
	PENALTIES / OVERDRAFT CHARGES VI 18	75
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,218
	MESSENGER SERVICE	0
		0
		25,302

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	169,905
	UNEMPLOYMENT COMPENSATION XIX D	12,798
	WORKERS COMPENSATION INSURANC XIX D	50,121
	HOSPITALIZATION INSURANCE XIX D	170,882
	EMPLOYEE BENEFITS - OTHER XIX D	903
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	501 PLAN EXPENSE XIX D	1,964
	CHICAGO HEAD TAX XIX D	0
		0
		406,573
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,195
		1,195
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	6,451
		6,451
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	113,911
		113,911
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

874,542

**DOBSON PLAZA  
SCHEDULES  
12/31/2007**

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

TOTAL FOOD PURCHASE	131,812
LESS SALES TAX	(788)
NET FOOD	<u>131,024</u>
TOTAL PATIENT CENSUS	30,654
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	91,962
ADD # EMPLOYEE MEALS/DAY	<u>20</u>
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	7,300
PATIENT MEALS	91,962
ADD EMPLOYEE MEALS	<u>7,300</u>
TOTAL MEALS/YEAR	99,262
NET FOOD	131,024
DIVIDE TOTAL MEALS/YEAR	<u>99,262</u>
COST PER MEAL	1.32
TIME EMPLOYEE MEALS	<u>7,300</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><b>9,636</b></u>
	=====

**TRANSPORTATION - STAFF**

NAME	DEPT	PURPOSE	MISC	AUTO ALLOW J GRODETZ
*****	*****	*****	*****	*****
01/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
02/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
02/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	119.75	
02/07 CITY OF CHICAGO	FACILITY		90.00	
02/07 SAM'S CLUB	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	26.45	
03/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
03/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	221.76	
04/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
05/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
05/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	367.26	
06/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
06/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	155.05	
07/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
07/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	121.19	
07/07 SAM'S CLUB	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	40.00	
08/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
08/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	291.08	
08/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	13.00	
08/07 SECRETARY OF STATE		STATE LICENSE	78.00	
09/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
09/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	102.70	
10/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
10/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	103.05	
10/07 ROCHEL PERLMAN			19.00	
11/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
11/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	122.19	
11/07 CITY OF EVANSTON	FACILITY	CITY LICENSE	60.00	
12/07 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		161.54
12/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	108.34	
12/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	57.87	
12/07 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	26.53	
TOTAL			2,123.22	4,200.04
			=====	=====

**TOTAL STAFF TRANSPORTATION:**

**6,323.26**

Facility Name & ID Number **DOBSON PLAZA**

#0008136

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			72,219	72,219		72,219	9,898	82,117			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			325,870	325,870		325,870	(66,377)	259,493			32
33	Real Estate Taxes			125,792	125,792		125,792		125,792			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,289	2,289		2,289		2,289			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			526,170	526,170		526,170	(56,479)	469,691			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		98,260	27,057	125,317		125,317		125,317			39
40	Barber and Beauty Shops			1,975	1,975		1,975		1,975			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,108	53,108		53,108		53,108			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		98,260	82,140	180,400		180,400		180,400			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,226,782	376,746	1,482,852	4,086,380		4,086,380	(100,874)	3,985,506			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:

**01/01/2007**

Ending:

**12/31/2007**

**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>BHF 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	9,898	30		9
10	Interest and Other Investment Income	(66,367)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(788)	2		13
14	Non-Care Related Interest	(10)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(128)	25		16
17	Non-Care Related Fees	(405)	20		17
18	Fines and Penalties	(75)	21		18
19	Entertainment				19
20	Contributions	(489)	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	(15,789)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(27,774)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	1,053			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (100,874)		\$	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (100,874)		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 3,103	6	1
2	SILVER CONNECTION-PATIENT RECRUITMENT	(2,250)	19	2
3	POST-CLOSING ACCRUAL-BACKGROUND CHECK	200	20	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>	1,053		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA# 0008136

Report Period Beginning:

01/01/2007

Ending:

12/31/2007**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(788)	0	0	0	0	0	0	0	0	0	0	(788)	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	3,103	0	0	0	0	0	0	0	0	0	0	3,103	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>2,315</b>	<b>0</b>	<b>2,315</b>	<b>8</b>									
	<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>	<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>16</b>
	<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	(2,250)	0	0	0	0	0	0	0	0	0	0	(2,250)	19
20	Fees, Subscriptions & Promotions	(44,257)	0	0	0	0	0	0	0	0	0	0	(44,257)	20
21	Clerical & General Office Expenses	(75)	0	0	0	0	0	0	0	0	0	0	(75)	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	(128)	0	0	0	0	0	0	0	0	0	0	(128)	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>(46,710)</b>	<b>0</b>	<b>(46,710)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(44,395)</b>	<b>0</b>	<b>(44,395)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA

# 0008136

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	9,898	0	0	0	0	0	0	0	0	0	0	9,898	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(66,377)	0	0	0	0	0	0	0	0	0	0	(66,377)	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>(56,479)</b>	<b>0</b>	<b>(56,479)</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>(100,874)</b>	<b>0</b>	<b>(100,874)</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
	SEE ATTACHED					

**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	Total		\$			\$	\$ *	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:

01/01/2007

Ending:

12/31/2007

## 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	645,438	33	55.00	SALARY	\$ 64,971	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	\$ 64,971		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: 01/01/2007 Ending: 2/31/2007

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:

**01/01/2007**

Ending:

**12/31/2007**

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	\$ 5,010,624	12/16/09	6.0000	\$ 308,910	1						
2	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS		12/16/04	17,760	7,104			3,552	2						
3												3						
4	NISSAN		X	AUTO LOAN	\$549.87	03/04/03	29,883		02/04/08	3.9700	160	4						
5	LEXUS		X	AUTO LOAN	\$606.41	09/30/03	27,987	35,811	09/30/07		3,062	5						
<b>Working Capital</b>																		
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$9,226.40	06/01/06	110,717		06/01/07		4,084	6						
7	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$9,666.57	06/01/07	115,999	48,333	06/01/08		3,667	7						
8	NATIONAL REPUBLIC BK		X	WORKING CAPITAL	2333.00+INT	04/01/03	140,000	9,334		PRIME+	2,425	8						
9	TOTAL Facility Related				\$59,699.25		\$ 5,942,346	\$ 5,111,206			\$ 325,860	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES							10	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 10	14						
15	TOTALS (line 9+line14)						\$ 5,942,346	\$ 5,111,206			\$ 325,870	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 2006 report.

\$ **122,770** 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.)

\$ **123,662** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **892** 3

4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **124,900** 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.

\$ **125,792** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>114,247</b>	8
	2003	<b>117,516</b>	9
	2004	<b>118,491</b>	10
	2005	<b>121,551</b>	11
	2006	<b>123,662</b>	12

<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2006	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

**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 2006 TAX BILL.**

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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>2,166.29</u>	\$ <u>2,166.29</u>
2. <u>10-25-220-015-0000</u>	<u>NURSING HOME</u>	\$ <u>121,495.49</u>	\$ <u>121,495.49</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>123,661.78</u>	\$ <u>123,661.78</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

01/01/2007 Ending:

12/31/2007

**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:

01/01/2007 Ending: 12/31/2007

**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)	497,821	5
6	2		1971	11,147		8-12			11,147	6
7	4		1987	64,011		30	1,067	1,067	7,469	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	243	5,223	12
13	LANDSCAPING		1988	6,905		10			6,905	13
14	LAND IMPROVEMENTS - SEWER		1988	5,650		25	226	226	4,256	14
15	LAND IMPROVEMENTS - FENCING		1988	1,878		15			1,878	15
16	LAND IMPROVEMENTS - PAVING		1988	12,335		20	617	617	11,620	16
17	OUTSIDE SIGN		1988	2,473		12			2,473	17
18	SPRINKLER SYSTEM		1988	42,241		25	1,690	1,690	31,828	18
19	HEATING, VENTILATION, & A/C		1988	48,620		20	2,431	2,431	45,784	19
20	PLUMBING COMPOSITE		1988	63,062		25	2,522	2,522	48,001	20
21	ELECTRICAL WIRING		1988	115,484		20	5,774	5,774	108,744	21
22	BRICK-ENCLOSED GENERATOR		1989	1,375		25	55	55	963	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)	147,114	25
26	CANOPY SIGN		1999	8,000	205	39	205		1,717	26
27	ELEVATOR REPAIR		1999	1,990	51	39	51		419	27
28	FIRE DAMPERS / AIR INTAKES		2000	10,515	382	27.5	382		2,913	28
29	ELEVATOR UPGRADE / AIR INTAKES		2000	28,259	1,028	27.5	1,028		7,325	29
30	ELEVATOR UPGRADE		2001	18,977	690	27.5	690		4,686	30
31	CARPETING		2001	25,597		10	2,560	2,560	16,640	31
32	HEAT EXCHANGER / FIRE SUPPRESSION SYSTEM		2003	11,572	421	27.5	421		1,991	32
33	HYDRAULIC ELEVATOR PUMP		2006	10,772	392	27.5	392		702	33
34	BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER		2006	29,463	1,071	27.5	1,071		1,713	34
35	NURSG STN/BATHRMS/PLUMBG/FLOORING/ROOF FASCIA		2007	54,157	1,056	27.5	1,056		1,058	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)	\$ 2,313,886	\$ 59,575		\$ 59,141	\$ (452)	\$ 1,238,880	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:

**01/01/2007**

Ending:

**12/31/2007**

**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	\$ 631	\$ 2,390	\$ 1,759	8-10 YRS	\$ 14,904	71
72	Current Year Purchases	9,442	1,888	481	(1,407)	8-10 YRS	481	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 33,124	\$ 2,519	\$ 2,871	\$ 352		\$ 15,385	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	\$		\$ 10,650	76
77	ACTIVITIES, MAINT,	'95 JEEP	2001	19,087	1,775		(1,775)	4 YRS	19,087	77
78	& PURCHASING,	'03 NISSAN	2003	30,491	1,775	3,810	2,035	4 YRS	30,491	78
79	ETC	'07 LEXUS RX400H	2006	58,079	4,800	14,520	9,720	4 YRS	7,260	79
80	<b>TOTALS</b>			\$ 176,098	\$ 10,125	\$ 20,105	\$ 9,980		\$ 67,488	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)	\$ 2,603,614	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,219	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,117	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,898	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,321,753	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	SUNROOM	\$ 29,881	92
93			93
94			94
95		\$ 29,881	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	<b>TOTAL</b>				\$			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: \$ 2,289 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	<b>TOTAL</b>		\$	\$	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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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	\$	\$	\$	\$
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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	\$		\$ 23,789	\$		\$ 23,789	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,050			3,050	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			218			218	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				83,908		83,908	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					14,352		14,352	13
14	<b>TOTAL</b>			\$		\$ 27,057	\$ 98,260		\$ 125,317	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: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 1,526,572	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	964,429		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,736		6
7	Other Prepaid Expenses	7,797		7
8	Accounts Receivable (owners or related parties)	498,677		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,048,211	\$	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	290,485		15
16	Equipment, at Historical Cost	211,694		16
17	Accumulated Depreciation (book methods)	(1,370,882)		17
18	Deferred Charges	7,104		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>	233,893		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,535,084	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,583,295	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 213,567	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,388		28
29	Short-Term Notes Payable	66,242		29
30	Accrued Salaries Payable	104,614		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,946		31
32	Accrued Real Estate Taxes(Sch.IX-B)	124,900		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>DEFERRED INCOME</u>	180,584		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 728,241	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	27,235		39
40	Mortgage Payable	5,010,624		40
41	Bonds Payable			41
42	Deferred Compensation	559,585		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)	\$ 5,597,444	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 6,325,685	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,742,390)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,583,295	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(2,080,664)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2006 IL REPLACEMENT TAX</b>	<b>(14,510)</b>	<b>3</b>
<b>4</b>	<b>POST CLOSING MEDICARE RUGS ADJ</b>	<b>28,080</b>	<b>4</b>
<b>5</b>	<b>POST CLOSING EXPENSE ADJ</b>	<b>(9,963)</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(2,077,057)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>874,667</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>(540,000)</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>334,667</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>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,742,390)</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	\$ 4,750,479	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,750,479	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	144,201	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 144,201	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>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	66,367	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 66,367	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>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,961,047	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	575,898	31
32	Health Care	1,890,527	32
33	General Administration	913,385	33
	<b>B. Capital Expense</b>		
34	Ownership	526,170	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	127,292	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>	\$ 4,086,380	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	874,667	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 874,667	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:

01/01/2007

Ending:

12/31/2007

**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	1,944	2,152	\$ 77,899	\$ 36.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,648	21,708	650,001	29.94	3
4	Licensed Practical Nurses	7,196	7,608	178,572	23.47	4
5	CNAs & Orderlies	51,959	57,385	582,722	10.15	5
6	CNA Trainees					6
7	Licensed Therapist	733	744	20,826	27.99	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,149	2,490	40,836	16.40	9
10	Activity Assistants	2,163	2,272	31,397	13.82	10
11	Social Service Workers	940	932	23,603	25.33	11
12	Dietician					12
13	Food Service Supervisor	665	665	15,502	23.31	13
14	Head Cook	3,227	3,785	39,305	10.38	14
15	Cook Helpers/Assistants	5,858	6,363	47,752	7.50	15
16	Dishwashers					16
17	Maintenance Workers	5,056	5,918	52,449	8.86	17
18	Housekeepers	2,207	2,542	19,059	7.50	18
19	Laundry	4,860	5,210	38,026	7.30	19
20	Administrator	2,085	2,085	64,971	31.16	20
21	Assistant Administrator	2,086	2,086	71,692	34.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,699	7,346	115,387	15.71	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	2,113	2,341	26,025	11.12	31
32	Other Health C: <u>ADMISS'NS/QA</u>	4,597	4,597	130,758	28.44	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,185	138,229	\$ 2,226,782 *	\$ 16.11	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	\$ 46,206	1-3	35
36	Medical Director	O	6,000	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	1,009	10-3	39
40	Physical Therapy Consultant	L	31,501	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)		\$ 92,780		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	23	\$ 457	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	23	\$ 457		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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	PAINT/DECORATING	2004	\$ 9,893	3	\$ 1,649	\$ 3,298	\$ 3,298	\$ 1,648	\$	\$	\$	\$	\$
2	PAINT/DECORATING	2005	4,833	3		806	1,611	1,611	805				
3	PAINT/DECORATING	2006	12,202	3			2,034	4,067	4,067	2,034			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$ 26,928		\$ 1,649	\$ 4,104	\$ 6,943	\$ 7,326	\$ 4,872	\$ 2,034	\$	\$	\$

Facility Name &amp; ID Number DOBSON PLAZA

# 0008136

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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. \$ 0 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. \$ 9,636 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 \$5,000, 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