

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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

<p>I. IDPH License ID Number: <u>0008136</u></p> <p>Facility Name: <u>DOBSON PLAZA</u></p> <p>Address: <u>120 DODGE AVENUE</u> <u>EVANSTON</u> <u>60202</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 869-7744</u> Fax # <u>(847) 570-0112</u></p> <p>HFS ID Number: <u>36-260166801</u></p> <p>Date of Initial License for Current Owners: <u>10/15/66</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>CHARLOTTE KOHN</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>CHARLOTTE KOHN</u> (Date) _____		(Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number DOBSON PLAZA

0008136 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

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

B. Census-For the entire report period.

	1 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	17,097	11,162	2,161	30,420	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,097	11,162	2,161	30,420	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.69%

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 2,161

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **DOBSON PLAZA** # **0008136** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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
	A. General Services										
1	Dietary	111,463	12,318	40,522	164,303		164,303		164,303		1
2	Food Purchase		126,259		126,259	(9,296)	116,963	(704)	116,259		2
3	Housekeeping	25,683	15,762		41,445		41,445		41,445		3
4	Laundry	34,264	8,301	925	43,490		43,490		43,490		4
5	Heat and Other Utilities			89,656	89,656		89,656		89,656		5
6	Maintenance	42,615	2,798	35,107	80,520		80,520	4,872	85,392		6
7	Other (specify):*			5,667	5,667		5,667		5,667		7
8	TOTAL General Services	214,025	165,438	171,877	551,340	(9,296)	542,044	4,168	546,212		8
	B. Health Care and Programs										
9	Medical Director			6,750	6,750		6,750		6,750		9
10	Nursing and Medical Records	1,672,325	64,455	8,501	1,745,281		1,745,281		1,745,281		10
10a	Therapy	7,544		59,760	67,304		67,304		67,304		10a
11	Activities	70,693	10,563		81,256		81,256		81,256		11
12	Social Services	20,308		3,840	24,148		24,148		24,148		12
13	CNA Training										13
14	Program Transportation			125	125		125		125		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,770,870	75,018	78,976	1,924,864		1,924,864		1,924,864		16
	C. General Administration										
17	Administrative	137,028			137,028		137,028		137,028		17
18	Directors Fees										18
19	Professional Services			52,101	52,101		52,101	(2,945)	49,156		19
20	Dues, Fees, Subscriptions & Promotions			53,736	53,736		53,736	(41,590)	12,146		20
21	Clerical & General Office Expenses	108,484	16,205	27,673	152,362		152,362	(3,343)	149,019		21
22	Employee Benefits & Payroll Taxes			408,884	408,884	9,296	418,180		418,180		22
23	Inservice Training & Education			529	529		529		529		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			6,480	6,480		6,480		6,480		25
26	Insurance-Prop.Liab.Malpractice			109,961	109,961		109,961		109,961		26
27	Other (specify):*										27
28	TOTAL General Administration	245,512	16,205	659,364	921,081	9,296	930,377	(47,878)	882,499		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,230,407	256,661	910,217	3,397,285		3,397,285	(43,710)	3,353,575		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	40,477
	REPAIRS & MAINTENANCE	0
	OUTSIDE SERVICES	45
3	HOUSEKEEPING	
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	925
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	35,611
	ELECTRICITY	29,881
	WATER	23,387
	CABLE TV - LOBBY	777
		0
6	MAINTENANCE	
	GROUND MAINTENANCE	3,417
	PAINTING & DECORATING	2,660
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	18,223
	ELEVATOR MAINTENANCE & REPAIR	4,160
	OUTSIDE LABOR	116
	EXTERMINATING SERVICE	2,496
	FIRE SERVICE	4,035
		0
		0
		0
		0
		35,107
7	OTHER	
	SCAVENGER	5,667
	SECURITY SERVICE	0
		0
		0
		5,667
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,750
		6,750

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	492
	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	6,030
	PHARMACY CONSULTANT XVIII B 39-2	1,979
	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
		8,501
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	500
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	59,260
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		59,760
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
	CLERGY	0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,840
		0
		3,840
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	125
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	4,341
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	47,760
		0
		52,101
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	14,655
	EMPLOYEE WANT ADS XIX F	3,000
	CONTRIBUTIONS VI 20 XIX F	300
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	8,106
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	26,635
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	210
	PATIENT BACKGROUND CHECKS XIX F	830
		53,736
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,027
	EQUIPMENT REPAIR & MAINTENANCE	2,615
	OUTSIDE CLERICAL SERVICES	3,914
	PENALTIES / OVERDRAFT CHARGES VI 18	3,343
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,774
	MESSENGER SERVICE	0
		0
		27,673

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	170,627
	UNEMPLOYMENT COMPENSATION XIX D	11,209
	WORKERS COMPENSATION INSURANC XIX D	49,643
	HOSPITALIZATION INSURANCE XIX D	172,027
	EMPLOYEE BENEFITS - OTHER XIX D	3,500
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	501 PLAN EXPENSE XIX D	1,878
	CHICAGO HEAD TAX XIX D	0
		0
		408,884
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	529
		529
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	6,480
		6,480
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	109,961
		109,961
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

910,217

DOBSON PLAZA
SCHEDULES
12/31/2008

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

TOTAL FOOD PURCHASE	126,259
LESS SALES TAX	(704)
NET FOOD	<u>125,555</u>
TOTAL PATIENT CENSUS	30,420
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	91,260
ADD # EMPLOYEE MEALS/DAY	20
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	7,320
PATIENT MEALS	91,260
ADD EMPLOYEE MEALS	<u>7,320</u>
TOTAL MEALS/YEAR	98,580
NET FOOD	125,555
DIVIDE TOTAL MEALS/YEAR	<u>98,580</u>
COST PER MEAL	1.27
TIME EMPLOYEE MEALS	<u>7,320</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>9,296</u>
	=====

PAGE 3 LINE 25
TRANSPORTATION - STAFF

	NAME	PURPOSE	AMOUNT	AMOUNT
*****	*****	*****	*****	*****
JAN	JOYCE GRODETZ	AUTO ALLOWANCE		484.62
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	142.14	
FEB	JOYCE GRODETZ	AUTO ALLOWANCE		323.08
	PETTY CASH	Gasoline for facility banking, maintenance, marketing & activities	40.00	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	23.03	
MAR	JOYCE GRODETZ	AUTO ALLOWANCE		323.08
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	110.87	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	103.04	
APR	JOYCE GRODETZ	AUTO ALLOWANCE		323.08
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	106.89	
MAY	JOYCE GRODETZ	AUTO ALLOWANCE		484.62
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	13.10	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	90.42	
JUN	JOYCE GRODETZ	AUTO ALLOWANCE		323.08
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	174.43	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	72.83	
	PETT Y CASH	Gasoline for facility banking, maintenance, marketing & activities	19.25	
JUL	JOYCE GRODETZ	AUTO ALLOWANCE		323.08
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	183.20	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	30.40	
	SECRETARY OF STATE	STATE LICENSE	78.00	
AUG	JOYCE GRODETZ	AUTO ALLOWANCE		323.08
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	57.37	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	172.45	
SEP	JOYCE GRODETZ	AUTO ALLOWANCE		323.08
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	137.73	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	118.19	
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	4.00	
	PETT Y CASH	Gasoline for facility banking, maintenance, marketing & activities	4.00	
OCT	JOYCE GRODETZ	AUTO ALLOWANCE		484.62
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	64.80	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	190.40	
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	17.00	
NOV	JOYCE GRODETZ	AUTO ALLOWANCE		323.08
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	67.18	
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	59.51	
DEC	JOYCE GRODETZ	AUTO ALLOWANCE		161.54
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	98.78	
	CHASE CARD	Gasoline for facility banking, maintenance, marketing & activities	81.39	
	SAM'S CLUB	Gasoline for facility banking, maintenance, marketing & activities	20.00	

TOTAL			<u>2,280.40</u>	<u>4,200.04</u>
			=====	=====
		TOTAL STAFF TRANSPORTATION	<u>6,480.44</u>	
			=====	

Facility Name & ID Number **DOBSON PLAZA**

#0008136

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	
	D. Ownership											
30	Depreciation			82,781	82,781		82,781	4,332	87,113			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			314,541	314,541		314,541	(98,381)	216,160			32
33	Real Estate Taxes			146,471	146,471		146,471		146,471			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			2,433	2,433		2,433		2,433			36
37	TOTAL Ownership			546,226	546,226		546,226	(94,049)	452,177			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,030	71,109	168,139		168,139		168,139			39
40	Barber and Beauty Shops			1,985	1,985		1,985		1,985			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,254	53,254		53,254		53,254			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		97,030	126,348	223,378		223,378		223,378			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,230,407	353,691	1,582,791	4,166,889		4,166,889	(137,759)	4,029,130			45

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

DOBSON PLAZA

ID# 0008136

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINT	\$ 4,872	6	1
2	PATIENT RECRUITMENT	(2,945)	19	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	Total	1,927		49

STATE OF ILLINOIS

Summary A

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

01/01/2008

Ending: 12/31/2008

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	(704)	0	0	0	0	0	0	0	0	0	0	(704)	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	4,872	0	0	0	0	0	0	0	0	0	0	4,872	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	4,168	0	4,168	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,945)	0	0	0	0	0	0	0	0	0	0	(2,945)	19
20	Fees, Subscriptions & Promotions	(41,590)	0	0	0	0	0	0	0	0	0	0	(41,590)	20
21	Clerical & General Office Expenses	(3,343)	0	0	0	0	0	0	0	0	0	0	(3,343)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(47,878)	0	(47,878)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,710)	0	(43,710)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA# 0008136

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	4,332	0	0	0	0	0	0	0	0	0	0	4,332	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(98,381)	0	0	0	0	0	0	0	0	0	0	(98,381)	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	TOTAL Ownership	(94,049)	0	(94,049)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(137,759)	0	(137,759)	45									

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
		BIRCHWOOD PLAZA INC	CHICAGO, IL			
	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 & ID Number

DOBSON PLAZA

#

0008136

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	692,053	33	55.00	SALARY	\$ 65,143	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	\$ 65,143		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: 01/01/2008 Ending: 2/31/2008

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:

01/01/2008

Ending:

12/31/2008

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			
A. Directly Facility Related																		
Long-Term																		
1	MB FINANCIAL		X	MORTGAGE	\$39,650.00	12/16/04	\$ 5,500,000	\$ 4,835,516	12/16/09	6.0000	\$ 300,808	1						
2	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS		12/16/04	17,760	3,552			3,552	2						
3												3						
4	NATIONAL REPUBLIC BK		X	WORKING CAPITAL	2333.00+INT	04/01/03	140,000		04/01/08	PRIME+	130	4						
5	LEXUS		X	AUTO LOAN	\$917.43	09/30/06	45,653	27,235	09/30/11		2,434	5						
Working Capital																		
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$9,666.57	06/01/07	115,999		06/01/08		3,667	6						
7	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$9,687.74	06/01/08	116,253	58,126	06/01/09	5.2500	2,862	7						
8	MB FINANCIAL		X	LINE OF CREDIT	DEMAND	12/08	500,000	500,000		PRIME+	580	8						
9	TOTAL Facility Related				\$59,921.74		\$ 6,435,665	\$ 5,424,429			\$ 314,033	9						
B. Non-Facility Related*																		
10	NATIONAL REPUBLIC BK		X	INTEREST ON OVERDRAFT							508	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 508	14						
15	TOTALS (line 9+line14)						\$ 6,435,665	\$ 5,424,429			\$ 314,541	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 2007 report.		\$	124,900	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.)		\$	135,011	2
3. Under or (over) accrual (line 2 minus line 1).		\$	10,111	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	136,360	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.		\$	146,471	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	117,516	8
	2004	118,491	9
	2005	121,551	10
	2006	123,662	11
	2007	135,011	12

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2007 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>133,090.04</u>	\$ <u>133,090.04</u>
2. <u>10-25-220-015-0000</u>	<u>NURSING HOME</u>	\$ <u>1,920.49</u>	\$ <u>1,920.49</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>135,010.53</u>	\$ <u>135,010.53</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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>\$ 80,509</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>7,728</u>		<u>\$ 80,509</u>	<u>3</u>

Facility Name & ID Number DOBSON PLAZA

0008136

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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
	Improvement Type**									
9	ELECTRICAL & PLUMBING		1976	1,027		8			1,027	9
10	SPRINKLER SYSTEM		1982	9,921		15			9,921	10
11	NURSING OFFICE		1982	891		15			891	11
12	RENOVATE NURSING STATION		1986	5,223		20			5,223	12
13	LANDSCAPING		1988	6,905		10			6,905	13
14	LAND IMPROVEMENTS - SEWER		1988	5,650		25	226	226	4,482	14
15	LAND IMPROVEMENTS - FENCING		1988	1,878		15			1,878	15
16	LAND IMPROVEMENTS - PAVING		1988	12,335		20	617	617	12,237	16
17	OUTSIDE SIGN		1988	2,473		12			2,473	17
18	SPRINKLER SYSTEM		1988	42,241		25	1,690	1,690	33,518	18
19	HEATING, VENTILATION, & A/C		1988	48,620		20	2,431	2,431	48,215	19
20	PLUMBING COMPOSITE		1988	63,062		25	2,522	2,522	50,523	20
21	ELECTRICAL WIRING		1988	115,484		20	5,774	5,774	114,518	21
22	BRICK-ENCLOSED GENERATOR		1989	1,375		25	55	55	1,018	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)	160,488	25
26	CANOPY SIGN		1999	8,000	205	39	205		1,922	26
27	ELEVATOR REPAIR		1999	1,990	51	39	51		470	27
28	FIRE DAMPERS / AIR INTAKES		2000	10,515	382	27.5	382		3,295	28
29	ELEVATOR UPGRADE / AIR INTAKES		2000	28,259	1,028	27.5	1,028		8,353	29
30	ELEVATOR UPGRADE		2001	18,977	690	27.5	690		5,376	30
31	CARPETING		2001	25,597		10	2,560	2,560	19,200	31
32	HEAT EXCHANGER / FIRE SUPPRESSION SYSTEM		2003	11,572	421	27.5	421		2,412	32
33	HYDRAULIC ELEVATOR PUMP		2006	10,772	392	27.5	392		1,094	33
34	BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER		2006	29,463	1,071	27.5	1,071		2,784	34
35	NURSG STN/BATHRMS/PLUMBING/FLOORING/ROOF FASCIA		2007	53,627	1,949	27.5	1,949		3,007	35
36	BEAUTY SHOP DRYWALL,CABINETRY,PLUMBING,TILE		2007	7,287	254	27.5	254		254	36

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

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

See Page 12A, Line 70 for total

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	METAL EXIT DOORS / FIRE RETARDANT CEMENT	2008	\$ 8,404	\$ 271	27.5	\$ 271		\$ 271	37
38	PT,AAD,DAYRMS-DRYWALL,FLOORING,STUDS,JOIST	2008	19,380	558	27.5	558		558	38
39	REMODEL BATHROOMS / REPIPE WATER LINES	2008	17,490	413	27.5	413		413	39
40	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	59	27.5	59		59	40
41	NURSING STATION/LOWER LEVEL ROOM/BATHROOM	2008	38,800	192	27.5	192		192	41
42	ROOF	2008	18,500	84	27.5	84		84	42
43	CARPETING	2008	11,289	5,911	10	1,129	(4,782)	1,129	43
44	DRIVEWAY/PARKINGLOT	2008	18,807	626	15	626		626	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
57									57
58									58
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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)		\$ 2,456,328	\$ 68,836		\$ 63,359	\$ (5,477)	\$ 1,277,904	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:

01/01/2008

Ending:

12/31/2008

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	\$ 33,124	\$ 3,159	\$ 3,352	\$ 193	8-10 YRS	\$ 18,737	71
72	Current Year Purchases	5,944	3,310	297	(3,013)	10 YRS	297	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 39,068	\$ 6,469	\$ 3,649	\$ (2,820)		\$ 19,034	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	\$	4 YRS	\$ 10,650	76
77	ACTIVITIES, MAINT,	'95 JEEP	2001	19,087	1,076		(1,076)	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	2,850	14,520	11,670	4 YRS	7,260	79
80	TOTALS			\$ 176,098	\$ 7,476	\$ 20,105	\$ 12,629		\$ 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)	\$ 2,752,003	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 82,781	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 87,113	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,332	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,364,426	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	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	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: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	\$		\$ 69,629	\$		\$ 69,629	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			908			908	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			572			572	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				90,000		90,000	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					7,030		7,030	13
14	TOTAL			\$		\$ 71,109	\$ 97,030		\$ 168,139	14

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

Facility Name & ID Number DOBSON PLAZA

0008136

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 592,155	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,449,162		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,560		6
7	Other Prepaid Expenses	7,947		7
8	Accounts Receivable (owners or related parties)	1,145,000		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,245,824	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	80,506		13
14	Buildings, at Historical Cost	2,082,284		14
15	Leasehold Improvements, at Historical Cost	433,427		15
16	Equipment, at Historical Cost	217,638		16
17	Accumulated Depreciation (book methods)	(1,453,664)		17
18	Deferred Charges	3,552		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>	286,035		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,649,778	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,895,602	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 253,935	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,840		28
29	Short-Term Notes Payable	742,378		29
30	Accrued Salaries Payable	119,490		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,818		31
32	Accrued Real Estate Taxes(Sch.IX-B)	136,360		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DEFERRED INCOME</u>	197,755		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,495,576	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	17,983		39
40	Mortgage Payable	4,660,516		40
41	Bonds Payable			41
42	Deferred Compensation	660,705		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,339,204	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,834,780	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,939,557)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,895,223	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,742,390)	1
2	Restatements (describe):		2
3	2007 IL REPLACEMENT TAX	(14,194)	3
4	ROUNDING	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,756,583)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	953,021	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,135,995)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (182,974)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,939,557)	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,882,471	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,882,471	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	139,566	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 139,566	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	97,873	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 97,873	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,119,910	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	551,340	31
32	Health Care	1,924,864	32
33	General Administration	921,081	33
	B. Capital Expense		
34	Ownership	546,226	34
	C. Ancillary Expense		
35	Special Cost Centers	170,124	35
36	Provider Participation Fee	53,254	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,166,889	40
41	Income before Income Taxes (line 30 minus line 40)**	953,021	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 953,021	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number DOBSON PLAZA

0008136

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	1,752	1,963	\$ 72,732	\$ 37.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,645	21,732	654,281	30.11	3
4	Licensed Practical Nurses	7,145	7,651	175,073	22.88	4
5	CNAs & Orderlies	50,281	55,244	596,559	10.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	149	149	7,544	50.63	8
9	Activity Director	1,941	2,239	37,980	16.96	9
10	Activity Assistants	2,209	2,327	32,713	14.06	10
11	Social Service Workers	790	790	20,308	25.71	11
12	Dietician					12
13	Food Service Supervisor	538	538	11,925	22.17	13
14	Head Cook	3,669	4,057	43,189	10.65	14
15	Cook Helpers/Assistants	6,374	7,016	56,349	8.03	15
16	Dishwashers					16
17	Maintenance Workers	3,884	4,554	42,615	9.36	17
18	Housekeepers	3,012	3,311	25,683	7.76	18
19	Laundry	4,123	4,465	34,264	7.67	19
20	Administrator	2,091	2,091	65,143	31.15	20
21	Assistant Administrator	2,091	2,091	71,885	34.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,799	6,449	108,484	16.82	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	2,977	3,311	33,560	10.14	31
32	Other Health C: <u>ADMISS'NS/QA</u>	4,730	4,734	140,120	29.60	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,200	134,712	\$ 2,230,407 *	\$ 16.56	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	\$ 40,477	1-3	35
36	Medical Director	O	6,750	9-3	36
37	Medical Records Consultant	N	6,030	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,979	10-3	39
40	Physical Therapy Consultant	L	59,260	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)		\$ 118,336		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	11	\$ 376	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	10	116	10-3	52
53	TOTAL (lines 50 - 52)	21	\$ 492		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	5 Amount of Expense Amortized Per Year								
					6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012	14 FY2013
1	PAINT/DECORATING	2005	\$ 4,833	3	\$ 806	\$ 1,611	\$ 1,611	\$ 805	\$	\$	\$	\$	\$
2	PAINT/DECORATING	2006	12,202	3		2,034	4,067	4,067	2,034				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 17,035		\$ 806	\$ 3,645	\$ 5,678	\$ 4,872	\$ 2,034	\$	\$	\$	\$

Facility Name & ID Number DOBSON PLAZA

0008136

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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. \$ 53,254
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. \$ 9,296 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