

Facility Name & ID Number DOBSON PLAZA

0008136 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	<u>97</u>	Skilled (SNF)	<u>97</u>	<u>35,405</u>	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	<u>97</u>	TOTALS	<u>97</u>	<u>35,405</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>19,180</u>	<u>9,981</u>	<u>3,391</u>	<u>32,552</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,180</u>	<u>9,981</u>	<u>3,391</u>	<u>32,552</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.94%

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 3,391

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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number **DOBSON PLAZA** # **0008136** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

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	111,846	18,336	60,149	190,331		190,331		190,331		1
2	Food Purchase		129,859		129,859	(8,979)	120,880	(550)	120,330		2
3	Housekeeping	26,513	20,541		47,054		47,054		47,054		3
4	Laundry	36,490	7,752	1,955	46,197		46,197		46,197		4
5	Heat and Other Utilities			70,900	70,900		70,900		70,900		5
6	Maintenance	54,349	9,380	41,009	104,738		104,738	2,034	106,772		6
7	Other (specify):*			7,430	7,430		7,430		7,430		7
8	TOTAL General Services	229,198	185,868	181,443	596,509	(8,979)	587,530	1,484	589,014		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,746,237	78,046	8,242	1,832,525		1,832,525		1,832,525		10
10a	Therapy	100,948			100,948		100,948		100,948		10a
11	Activities	74,307	7,283	1,750	83,340		83,340		83,340		11
12	Social Services	11,125		3,840	14,965		14,965		14,965		12
13	CNA Training										13
14	Program Transportation			200	200		200		200		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,932,617	85,329	23,032	2,040,978		2,040,978		2,040,978		16
	C. General Administration										
17	Administrative	140,209			140,209		140,209		140,209		17
18	Directors Fees										18
19	Professional Services			83,107	83,107		83,107		83,107		19
20	Dues, Fees, Subscriptions & Promotions			40,851	40,851		40,851	(36,091)	4,760		20
21	Clerical & General Office Expenses	108,855	14,603	30,719	154,177		154,177		154,177		21
22	Employee Benefits & Payroll Taxes			405,063	405,063	8,979	414,042		414,042		22
23	Inservice Training & Education			879	879		879		879		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			9,339	9,339		9,339	(2,064)	7,275		25
26	Insurance-Prop.Liab.Malpractice			138,978	138,978		138,978		138,978		26
27	Other (specify):*			7,901	7,901		7,901	(7,901)			27
28	TOTAL General Administration	249,064	14,603	716,837	980,504	8,979	989,483	(46,056)	943,427		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,410,879	285,800	921,312	3,617,991		3,617,991	(44,572)	3,573,419		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	60,149
	REPAIRS & MAINTENANCE	0
		0
		60,149
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,955
		0
		1,955
5	HEAT & OTHER UTILITIES	
	GAS HEAT	20,431
	ELECTRICITY	26,112
	WATER	23,556
	CABLE TV - LOBBY	801
		0
		70,900
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,799
	PAINTING & DECORATING	4,484
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	21,942
	ELEVATOR MAINTENANCE & REPAIR	4,439
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,496
	FIRE SERVICE	4,849
		0
		0
		0
		0
		41,009
7	OTHER	
	SCAVENGER	7,430
	SECURITY SERVICE	0
		0
		0
		7,430
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	855
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	5,408
	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
		8,242
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULT# XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
	CLERGY	1,750
		1,750
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN 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	200
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	4,350
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	78,757
		0
		83,107
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,961
	EMPLOYEE WANT ADS XIX F	235
	CONTRIBUTIONS VI 20 XIX F	1,150
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	3,375
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	18,760
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	220
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	430
	PATIENT BACKGROUND CHECKS XIX F	720
		40,851
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,297
	EQUIPMENT REPAIR & MAINTENANCE	3,495
	OUTSIDE CLERICAL SERVICES	3,900
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	21,027
	MESSENGER SERVICE	0
		0
		30,719

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	183,695
	UNEMPLOYMENT COMPENSATION XIX D	10,755
	WORKERS COMPENSATION INSURANC XIX D	34,238
	HOSPITALIZATION INSURANCE XIX D	168,340
	EMPLOYEE BENEFITS - OTHER XIX D	8,354
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	501 PLAN EXPENSE XIX D	(319)
	CHICAGO HEAD TAX XIX D	0
		0
		405,063
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	879
		879
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,275
	AUTO EXPENSES-OTHER	2,064
		9,339
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	138,978
		138,978
27	OTHER	
	BAD DEBTS VI 24	7,901
		7,901

GRAND TOTAL COLUMN 3 OTHER

921,312

TRANSPORTATION - STAFF
PAGE 3 SCHEDULE V COLUMN 3 LINE 25

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

TOTAL FOOD PURCHASE	129,859
LESS SALES TAX	(550)
NET FOOD	<u>129,309</u>
TOTAL PATIENT CENSUS	32,552
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	<u>97,656</u>
ADD # EMPLOYEE MEALS/DAY	20
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	<u>7,300</u>
PATIENT MEALS	97,656
ADD EMPLOYEE MEALS	<u>7,300</u>
TOTAL MEALS/YEAR	<u>104,956</u>
NET FOOD	129,309
DIVIDE TOTAL MEALS/YEAR	<u>104,956</u>
COST PER MEAL	1.23
TIME EMPLOYEE MEALS	<u>7,300</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>8,979</u>
	=====

PROFESSIONAL FEES
PAGE 21 XIX. C.

ALPHA DATA SERVICES	DATA PROCESSING	4,350
FR&R	MEDICAID CONSULTANT	750
RICHARD PEELO	MEDICARE COST REPORT	3,000
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	18,850
MYRON TUSHBAI	ACCOUNTING	1,283
MICHIGAN PEER REVIEW	DISPUTE RESOLUTION SERVICES	2,000
FISK KART KATZ & REGAN	LEGAL	77
MUCH SHELIST	LEGAL	6,450
KEITH GOLDBERG	LEGAL	4,040
SIEGEL ALBIN	LEGAL	3,501
REIFF SCHRAMM KANTER	LEGAL	81
PERSONNEL PLANNING	UNEMPLOYMENT CONSULTANT	600
ECONOCARE	PURCHASING CONSULTANT	810
ADVANTAGE BENEFITS CONSULTANT	PENSION PLAN CONSULTANT	1,816
ISRAEL LICHTSHEIN	PURCHASING CONSULTANT	<u>35,499</u>

PROFESSIONAL FEES 83,107

NAME	DEPT	PURPOSE	MISC	AUTO ALLOW J GRODETZ
1.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
1.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	1.50	
2.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
2.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	350.92	
2.09 SAM'S CLUB	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	70.12	
3.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
3.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	216.54	
3.09 SAM'S CLUB	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	48.33	
4.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
5.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
5.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	411.71	
5.09 SAM'S CLUB		Gasoline for facility banking, maintenance, marketing & activities	36.77	
6.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
6.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	118.65	
6.09 SAM'S CLUB		Gasoline for facility banking, maintenance, marketing & activities	43.88	
7.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
7.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	202.56	
7.09 SAM'S CLUB	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	46.39	
7.09 SHALOM ZUPNICK		Gasoline for facility banking, maintenance, marketing & activities	100.00	
8.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
8.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	368.37	
9.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
9.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	128.59	
9.09 SAM'S CLUB	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	87.01	
9.09 SEC OF STATE		LICENSE	79.00	
9.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	2.00	
10.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
10.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	43.81	
10.09 SAM'S CLUB	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	71.73	
10.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	25.00	
10.09 ISRAEL LICHTSHEIN		Gasoline for facility banking, maintenance, marketing & activities	89.00	
11.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
11.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	67.76	
11.09 MARCELLA C		Gasoline for facility banking, maintenance, marketing & activities	23.00	
11.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	13.00	
11.09 PETTY CASH	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	44.25	
12.09 PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
12.09 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	95.96	
12.09 PETTY CASH	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	5.00	
12.06 CHASE CARD	FACILITY	Gasoline for facility banking, maintenance, marketing & activities	122.77	
TOTAL STAFF TRANSPORTATION:			2,913.62	4,361.58 7,275.20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			87,631	87,631		87,631	(6,748)	80,883			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			299,545	299,545		299,545	(40,367)	259,178			32
33	Real Estate Taxes			144,945	144,945		144,945		144,945			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			2,470	2,470		2,470		2,470			36
37	TOTAL Ownership			534,591	534,591		534,591	(47,115)	487,476			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,965	124,699	262,664		262,664		262,664			39
40	Barber and Beauty Shops			2,749	2,749		2,749		2,749			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	TOTAL Special Cost Centers		137,965	180,556	318,521		318,521		318,521			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,410,879	423,765	1,636,459	4,471,103		4,471,103	(91,687)	4,379,416			45

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

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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,748)	30		9
10	Interest and Other Investment Income	(40,305)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(550)	2		13
14	Non-Care Related Interest	(62)	32		14
15	Non-Care Related Owner's Transactions	(2,064)	25		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(220)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,150)	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	(7,901)	27		24
25	Fund Raising, Advertising and Promotional	(15,961)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(18,760)	20		28
29	Other-Attach Schedule XIX-H DEFERRED MAINT	2,034	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (91,687)		\$	30

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	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (91,687)		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	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

DOBSON PLAZA

ID# 0008136

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 2034	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,034		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA# 0008136

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(550)	0	0	0	0	0	0	0	0	0	0	(550)	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	2,034	0	0	0	0	0	0	0	0	0	0	2,034	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,484	0	1,484	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(36,091)	0	0	0	0	0	0	0	0	0	0	(36,091)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(2,064)	0	0	0	0	0	0	0	0	0	0	(2,064)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(7,901)	0	0	0	0	0	0	0	0	0	0	(7,901)	27
28	TOTAL General Administration	(46,056)	0	(46,056)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(44,572)	0	(44,572)	29									

STATE OF ILLINOIS

Facility Name & ID Number DOBSON PLAZA# 0008136

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(6,748)	0	0	0	0	0	0	0	0	0	0	(6,748)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(40,367)	0	0	0	0	0	0	0	0	0	0	(40,367)	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	(47,115)	0	0	0	0	0	0	0	0	0	0	(47,115)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(91,687)	0	0	0	0	0	0	0	0	0	0	(91,687)	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.

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DOBSON PLAZA

0008136

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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	636,747	33	55.00	SALARY	\$ 64,972	17-1	1
2	BARAK KOHN	BUILDING ADMIN	SUPERVISION	6.51	8,557	22.5	36.00	SALARY	8,604	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 73,576		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: 01/01/2009 Ending: 2/31/2009

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:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1	MB FINANCIAL		X	MORTGAGE	\$39,650.00	12/16/04	\$ 5,500,000	\$ 4,644,339	12/16/19	3.2500	\$ 279,401	1							
2	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS		12/16/04	17,760		12/16/09		3,552	2							
3												3							
4	MB FINANCIAL		X	LINE OF CREDIT	DEMAND	12/08	500,000			PRIME+	5,181	4							
5	LEXUS		X	AUTO LOAN	\$917.43	09/30/06	45,653	17,983	09/30/11		1,757	5							
	Working Capital																		
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$9,687.74	06/01/08	116,253		06/01/09	5.2500	2,937	6							
7	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	\$8,020.16	06/01/09	96,242	48,121	06/01/10	4.5000	2,072	7							
8	ISRAEL LICHTSHEIN	X		WORKING CAPITAL	\$8,750.00	12/12/08	100,000	8,750	12/12/09	5.0000	4,583	8							
9	TOTAL Facility Related				\$67,025.33		\$ 6,375,908	\$ 4,719,193			\$ 299,483	9							
	B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES							62	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ 62	14							
15	TOTALS (line 9+line14)						\$ 6,375,908	\$ 4,719,193			\$ 299,545	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

1. Real Estate Tax accrual used on 2008 report.		\$	136,360	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.)		\$	140,189	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,829	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	141,590	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 \$ <u>474</u> For <u>***</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(474)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	144,945	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	118,491	8	
	2005	121,551	9	
	2006	123,662	10	
	2007	135,011	11	
	2008	140,189	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 2008 TAX BILL.				
*** LINE 6 TOTAL REFUND = 231 FROM 1989 + 243 FROM 2000				
		FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number DOBSON PLAZA

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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

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Report Period Beginning:

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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)	521,089	5
6	2			1971	11,147		8-12			11,147	6
7	4			1987	64,011		30	1,067	1,067	8,536	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	4,708	14
15		LAND IMPROVEMENTS - FENCING		1988	1,878		15			1,878	15
16		LAND IMPROVEMENTS - PAVING		1988	12,335		20	98	98	12,335	16
17		OUTSIDE SIGN		1988	2,473		12			2,473	17
18		SPRINKLER SYSTEM		1988	42,241		25	1,690	1,690	35,208	18
19		HEATING, VENTILATION, & A/C		1988	48,620		20	405	405	48,620	19
20		PLUMBING COMPOSITE		1988	63,062		25	2,522	2,522	53,045	20
21		ELECTRICAL WIRING		1988	115,484		20	966	966	115,484	21
22		BRICK-ENCLOSED GENERATOR		1989	1,375		25	55	55	1,073	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)	173,862	25
26		CANOPY SIGN		1999	8,000	205	39	205		2,127	26
27		ELEVATOR REPAIR		1999	1,990	51	39	51		521	27
28		FIRE DAMPERS / AIR INTAKES		2000	10,515	382	27.5	382		3,677	28
29		ELEVATOR UPGRADE / AIR INTAKES		2000	28,259	1,028	27.5	1,028		9,381	29
30		ELEVATOR UPGRADE		2001	18,977	690	27.5	690		6,066	30
31		CARPETING		2001	25,597		10	2,560	2,560	21,760	31
32		HEAT EXCHANGER / FIRE SUPPRESSION SYSTEM		2003	11,572	421	27.5	421		2,833	32
33		HYDRAULIC ELEVATOR PUMP		2006	10,772	392	27.5	392		1,486	33
34		BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER		2006	29,463	1,071	27.5	1,071		3,855	34
35		NURSG STN/BATHRMS/PLUMBG/FLOORING/ROOF FASCIA		2007	53,627	1,949	27.5	1,949		4,956	35
36		BEAUTY SHOP DRYWALL,CABINETRY,PLUMBING,TILE		2007	7,287	265	27.5	265		519	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	\$ 306	27.5	\$ 306	\$	\$ 577	37
38	PT.AAD,DAYRMS-DRYWALL,FLOORING,STUDS,JOIST	2008	19,380	705	27.5	705		1,263	38
39	BATHRMS:TILE,FLOOR,DRYWALL,PAINT,PAPER,FIXTUR	2008	15,425	561	27.5	561		919	39
40	REPIPE KITCHEN WATER LINES	2008	2,065	75	27.5	75		130	40
41	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	110	27.5	110		169	41
42	LOWER LEVEL:REMOVE DOOR,WALL & BATHRM/ENLARGE ROOM & ADD NEW BATHROOM /DRYWALL/SOFFIT/WALLPAPER/PAINT/F								42
43	& NURSING STATION BUILT-IN CABINERY/COUNTERTC	2008	38,800	1,411	27.5	1,411		1,603	43
44	ROOF	2008	18,500	673	27.5	673		757	44
45	CARPETING	2008	11,259	2,139	10	1,126	(1,013)	2,255	45
46	DRIVEWAY/PARKINGLOT	2008	18,807	1,254	15	1,254		1,880	46
47	THERAPY ROOM WALL/SHELVING/CARPENTRY/6 DOORS	2009	5,530	184	27.5	184		184	47
48	ROOF/AC/CABLES/WIRING/SECURITY SYST/WINDOWS	2009	17,996	441	27.5	441		441	48
49	CARPENTRY/RECESSED LIGHTING/OUTLETS/PIPE/SUMP	2009	11,675	126	27.5	126		126	49
50	CERAMIC FLOOR/CARPENTRY/CLOSET/INTERCOM/CABI	2009	2,919	6	27.5	6		6	50
51	CARPETING/WINDOW TREATMENTS/WALLPAPER	2009	13,299	7,980	10	665	(7,315)	665	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)		\$ 2,507,717	\$ 76,704		\$ 60,328	\$ (16,376)	\$ 1,338,232	70

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

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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	\$ 39,068	\$ 2,866	\$ 3,946	\$ 1,080	8-10 YRS	\$ 22,980	71
72	Current Year Purchases	5,221	2,736	314	(2,422)	8-10 YRS	314	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 44,289	\$ 5,602	\$ 4,260	\$ (1,342)		\$ 23,294	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	\$ 12,425	76
77	ACTIVITIES, MAINT,	'95 JEEP	2001	19,087				4 YRS	19,087	77
78	& PURCHASING,	'03 NISSAN	2003	30,491	1,775		(1,775)	4 YRS	30,491	78
79	ETC	'07 LEXUS RX400H	2006	58,079	1,775	14,520	12,745	4 YRS	43,560	79
80	TOTALS			\$ 176,098	\$ 5,325	\$ 16,295	\$ 10,970		\$ 105,563	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)	\$ 2,808,613	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,631	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 80,883	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,748)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,467,089	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>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</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	\$		\$ 116,813	\$		\$ 116,813	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			427			427	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			7,459			7,459	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				117,548		117,548	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					20,417		20,417	13
14	TOTAL			\$		\$ 124,699	\$ 137,965		\$ 262,664	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: **01/01/2009**

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(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	\$ 793,621	\$	1
2	Cash-Patient Deposits	25,463		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,052,523		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,725		6
7	Other Prepaid Expenses	10,392		7
8	Accounts Receivable (owners or related parties)	672,073		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,608,797	\$	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	484,846		15
16	Equipment, at Historical Cost	222,859		16
17	Accumulated Depreciation (book methods)	(1,541,295)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): NY LIFE INSUR.CONTRACTS	340,374		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,669,574	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,278,371	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 296,700	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,463		28
29	Short-Term Notes Payable	312,854		29
30	Accrued Salaries Payable	136,947		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,511		31
32	Accrued Real Estate Taxes(Sch.IX-B)	141,590		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	DEFERRED INCOME	201,965		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,129,030	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	8,001		39
40	Mortgage Payable	4,398,339		40
41	Bonds Payable			41
42	Deferred Compensation	713,403		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,119,743	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,248,773	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,970,402)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,278,371	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,939,557)	1
2	Restatements (describe):		2
3	2008 IL REPLACEMENT TAX	(16,077)	3
4	POST-CLOSING ADJ FOR MEDICAL SUPPLIES/DRUGS	8,942	4
5	ROUNDING	(2)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,946,694)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,277,227	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	(1,300,935)	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)	\$ (23,708)	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)	\$ (1,970,402)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **DOBSON PLAZA**# **0008136**Report Period Beginning: **01/01/2009**Ending: **12/31/2009**

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	\$ 5,580,473	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,580,473	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	127,552	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 127,552	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***	40,305	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 40,305	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)	\$ 5,748,330	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	596,509	31
32	Health Care	2,040,978	32
33	General Administration	980,504	33
B. Capital Expense			
34	Ownership	534,591	34
C. Ancillary Expense			
35	Special Cost Centers	265,413	35
36	Provider Participation Fee	53,108	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,471,103	40
41	Income before Income Taxes (line 30 minus line 40)**	1,277,227	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,277,227	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: **01/01/2009**

Ending:

12/31/2009

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	1,906	2,150	\$ 84,908	\$ 39.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,139	23,590	707,777	30.00	3
4	Licensed Practical Nurses	5,574	6,087	139,518	22.92	4
5	CNAs & Orderlies	49,590	54,296	615,519	11.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,915	1,929	100,948	52.33	8
9	Activity Director	2,120	2,441	41,812	17.13	9
10	Activity Assistants	2,093	2,215	32,495	14.67	10
11	Social Service Workers	536	536	11,125	20.76	11
12	Dietician					12
13	Food Service Supervisor	365	365	8,126	22.26	13
14	Head Cook	3,558	3,956	44,259	11.19	14
15	Cook Helpers/Assistants	6,287	6,982	59,461	8.52	15
16	Dishwashers					16
17	Maintenance Workers	4,459	5,146	54,349	10.56	17
18	Housekeepers	2,915	3,260	26,513	8.13	18
19	Laundry	4,059	4,494	36,490	8.12	19
20	Administrator	2,125	2,125	64,972	30.58	20
21	Assistant Administrator	1,598	1,980	66,633	33.65	21
22	Other Administrative	572	572	8,604	15.04	22
23	Office Manager					23
24	Clerical	5,843	6,253	108,855	17.41	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	3,709	4,156	45,126	10.86	31
32	Other Health C: MDS/QA/ADMIT	4,934	5,049	153,389	30.38	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,297	137,582	\$ 2,410,879 *	\$ 17.52	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	\$ 60,149	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	5,408	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	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	3,840	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 80,376		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	35	\$ 520	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides	42	335	10-3	52
53	TOTAL (lines 50 - 52)	77	\$ 855		53

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	2006	\$ 12,202	3	\$ 2,034	\$ 4,067	\$ 4,067	\$ 2,034	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 12,202		\$ 2,034	\$ 4,067	\$ 4,067	\$ 2,034	\$	\$	\$	\$	\$

Facility Name & ID Number DOBSON PLAZA

0008136

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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. \$ 28,246 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. \$ 8,979 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.