

		FOR BHF USE					

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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>0051508</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: _____</p> <p>Date of Initial License for Current Owners: <u>05/01/2011</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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" 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>SANFORD BOKOR</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 type="checkbox"/> "Sub-S" Corp.			<input checked="" 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>01/01/2014</u> to <u>12/31/2014</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>SANFORD BOKOR</u> <u>PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KBKB, LTD.</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</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>SANFORD BOKOR</u> <u>PRESIDENT</u>	(Firm Name & Address) <u>KBKB, LTD.</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number DOBSON PLAZA

0051508 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,405	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,405	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,409	2,409	8
9	SNF/PED					9
10	ICF	15,621	12,390	1,652	29,663	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,621	12,390	4,061	32,072	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.59%

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 07/01/2011

J. Was the facility purchased or leased after January 1, 1978?

YES Date 07/01/2011 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 2,409

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

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	113,016	17,828	57,514	188,358		188,358		188,358		1
2	Food Purchase		161,229		161,229	(11,315)	149,914	(756)	149,158		2
3	Housekeeping	49,585	29,235		78,820		78,820		78,820		3
4	Laundry	32,003	10,674	3,510	46,187		46,187		46,187		4
5	Heat and Other Utilities			81,608	81,608		81,608		81,608		5
6	Maintenance	58,946	13,944	60,126	133,016		133,016		133,016		6
7	Other (specify):*			7,544	7,544		7,544		7,544		7
8	TOTAL General Services	253,550	232,910	210,302	696,762	(11,315)	685,447	(756)	684,691		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,999,597	100,314	14,116	2,114,027		2,114,027		2,114,027		10
10a	Therapy		3,768		3,768		3,768		3,768		10a
11	Activities	91,631	11,402	900	103,933		103,933		103,933		11
12	Social Services	27,057		3,840	30,897		30,897		30,897		12
13	CNA Training										13
14	Program Transportation			135	135		135		135		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,118,285	115,484	30,991	2,264,760		2,264,760		2,264,760		16
	C. General Administration										
17	Administrative	255,783			255,783		255,783	(73,494)	182,289		17
18	Directors Fees										18
19	Professional Services			82,991	82,991		82,991	10,724	93,715		19
20	Dues, Fees, Subscriptions & Promotions			70,949	70,949		70,949	(54,786)	16,163		20
21	Clerical & General Office Expenses	101,211	9,980	40,117	151,308		151,308	(110)	151,198		21
22	Employee Benefits & Payroll Taxes			533,756	533,756	11,315	545,071		545,071		22
23	Inservice Training & Education			818	818		818		818		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			6,810	6,810		6,810	(394)	6,416		25
26	Insurance-Prop.Liab.Malpractice			39,494	39,494		39,494		39,494		26
27	Other (specify):*										27
28	TOTAL General Administration	356,994	9,980	774,935	1,141,909	11,315	1,153,224	(118,060)	1,035,164		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,728,829	358,374	1,016,228	4,103,431		4,103,431	(118,816)	3,984,615		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	57,514
	REPAIRS & MAINTENANCE	0
		57,514
3	HOUSEKEEPING	
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,510
		3,510
5	HEAT & OTHER UTILITIES	
	GAS HEAT	21,602
	ELECTRICITY	30,038
	WATER	26,946
	CABLE TV - LOBBY	3,022
		81,608
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,209
	PAINTING & DECORATING	2,092
	BUILDING REPAIRS	3,200
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	25,690
	ELEVATOR MAINTENANCE & REPAIR	6,665
	OUTSIDE LABOR	770
	EXTERMINATING SERVICE	12,071
	FIRE SERVICE	6,429
		60,126
7	OTHER	
	SCAVENGER	7,544
	SECURITY SERVICE	0
		7,544
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,616
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	9,500
		14,116
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA 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	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
	CLERGY	900
		900
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,840
		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	135
		135
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
		0
18	DIRECTORS FEES	
	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	33,972
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	49,019
		82,991
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	36,380
	EMPLOYEE RECRUITMENT & WANT ADS XIX F	5,687
	CONTRIBUTIONS VI 20 XIX F	205
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	8,763
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	17,951
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	250
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,713
	PATIENT BACKGROUND CHECKS XIX F	0
		70,949
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,438
	EQUIPMENT REPAIR & MAINTENANCE	9,225
	OUTSIDE CLERICAL SERVICES	15,900
	PENALTIES / OVERDRAFT CHARGES VI 18	110
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	10,444
	MESSENGER SERVICE	0
		40,117

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	204,102
	UNEMPLOYMENT COMPENSATION XIX D	11,306
	WORKERS COMPENSATION INSURANC XIX D	48,094
	HOSPITALIZATION INSURANCE XIX D	273,929
	EMPLOYEE BENEFITS - OTHER XIX D	1,053
	EMPLOYEE PHYSICAL EXAMS XIX D	560
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
	501 PLAN - CASH VALUE ADJ	(5,288)
		533,756
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	818
		818
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	6,810
		6,810
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	39,494
		39,494
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,016,228

**DOBSON PLAZA
SCHEDULES
12/31/2014**

PG 23 XX. GENERAL INFORMATION QUESTION 12. ONE EMPLOYEE WORKS 50% ACCOUNTS PAYABLE/BOOKKEEPING AN

EMPLOYEE MEAL RECLASSIFICATION

PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE 161,229
LESS SALES TAX (756)
NET FOOD 160,473

TOTAL PATIENT CENSUS 32,072
TIMES 3 MEALS PER DAY 3
TOTAL PATIENT MEALS 96,216

ADD # EMPLOYEE MEALS/DAY 20
TIMES # DAYS 365
TOTAL EMPLOYEE MEALS 7,300

PATIENT MEALS 96,216
ADD EMPLOYEE MEALS 7,300
TOTAL MEALS/YEAR 103,516

NET FOOD 160,473
DIVIDE TOTAL MEALS/YEAR 103,516

COST PER MEAL 1.55
TIMES EMPLOYEE MEALS 7,300
EMPLOYEE MEAL RECLASSIFICATION 11,315

TRANSPORTATION - STAFF

PAGE 3 SCHEDULE V COLUMN 3 LINES 25

PURPOSE

MISC

1.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
1.14	P/C	GASOLINE	banking, maintenance, & activities, transportation	25.00
2.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
3.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
4.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
5.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
5.14	P/C	GASOLINE	banking, maintenance, & activities, transportation	45.00
5.14	CHASE	GASOLINE	banking, maintenance, & activities, transportation	125.70
6.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
6.14	P/C	GASOLINE	banking, maintenance, & activities, transportation	30.00
6.14	CHASE	GASOLINE	banking, maintenance, & activities, transportation	55.99
7.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
7.14	P/C	GASOLINE	banking, maintenance, & activities, transportation	94.40
7.14	CHASE	GASOLINE	banking, maintenance, & activities, transportation	131.47
8.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
8.14	CHRISTINE FOX. DON	GASOLINE	banking, maintenance, & activities, transportation	1,130.20
8.14	P/C	GASOLINE	banking, maintenance, & activities, transportation	92.00
8.14	CHASE	GASOLINE	banking, maintenance, & activities, transportation	121.44
9.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
10.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
10.14	M.SHAPIRO, OFFICE	GASOLINE	banking, maintenance, & activities, transportation	30.00
10.14	P/C	GASOLINE	banking, maintenance, & activities, transportation	40.00
10.14	CHASE	GASOLINE	banking, maintenance, & activities, transportation	124.44
11.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
11.14	M.SHAPIRO, OFFICE	GASOLINE	banking, maintenance, & activities, transportation	25.00
11.14	MARCELLA	GASOLINE	banking, maintenance, & activities, transportation	30.00
11.14	SAM'S CLUB	GASOLINE	banking, maintenance, & activities, transportation	14.62
12.14	PAYROLL - ALLOWANCE		banking, maintenance, & activities, transportation	
12.14	M.SHAPIRO, OFFICE	GASOLINE	banking, maintenance, & activities, transportation	35.00
12.14	CHASE	GASOLINE	banking, maintenance, & activities, transportation	46.14
12.14	SAM'S CLUB	GASOLINE	banking, maintenance, & activities, transportation	20.00

TOTAL TRANSPORTATION - STAFF

2,216

ID 50% ACTIVITIES

<u>J GRODETZ</u>	<u>TOTAL</u>
484.62	
323.08	
323.08	
323.08	
323.08	
323.08	
323.08	
323.08	
323.08	
323.08	
484.62	
323.08	
323.08	
<u>4,200</u>	<u>6,416</u>

Facility Name & ID Number

DOBSON PLAZA

#0051508

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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							66,005	66,005			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			734	734		734	113,803	114,537			32
33	Real Estate Taxes			242,438	242,438		242,438	(38,088)	204,350			33
34	Rent-Facility & Grounds			945,000	945,000		945,000	(945,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* STORAGE			4,058	4,058		4,058		4,058			36
37	TOTAL Ownership			1,192,230	1,192,230		1,192,230	(803,280)	388,950			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,553	399,938	519,491		519,491		519,491			39
40	Barber and Beauty Shops			856	856		856		856			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			231,158	231,158		231,158		231,158			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		119,553	631,952	751,505		751,505		751,505			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,728,829	477,927	2,840,410	6,047,166		6,047,166	(922,096)	5,125,070			45

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

Facility Name & ID Number **DOBSON PLAZA**

0051508

Report Period Beginning: **01/01/2014**

Ending: **12/31/2014**

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				9
10	Interest and Other Investment Income	(2,796)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(756)	2		13
14	Non-Care Related Interest	(734)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(394)	25		16
17	Non-Care Related Fees	(250)	20		17
18	Fines and Penalties	(110)	21		18
19	Entertainment				19
20	Contributions	(205)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(36,380)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(17,951)	20		28
29	Other-Attach Schedule SEE PG 5A	(75,475)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (135,051)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(787,045)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (787,045)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (922,096)		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

DOBSON PLAZA

ID# 0051508

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DISALLOWED LEGAL-CORPORATE MATTERS	\$ (1,981)	19	1
2	DISALLOWED EXCESS OWNER SALARY	(73,494)	17	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		(75,475)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA# 0051508

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(756)	0	0	0	0	0	0	0	0	0	0	(756)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(756)	0	0	0	0	0	0	0	0	0	0	(756)	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	(73,494)	0	0	0	0	0	0	0	0	0	0	(73,494)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,981)	12,705	0	0	0	0	0	0	0	0	0	10,724	19
20	Fees, Subscriptions & Promotions	(54,786)	0	0	0	0	0	0	0	0	0	0	(54,786)	20
21	Clerical & General Office Expenses	(110)	0	0	0	0	0	0	0	0	0	0	(110)	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	(394)	0	0	0	0	0	0	0	0	0	0	(394)	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	(130,765)	12,705	0	(118,060)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(131,521)	12,705	0	(118,816)	29								

STATE OF ILLINOIS

Facility Name & ID Number DOBSON PLAZA# 0051508

Report Period Beginning:

01/01/2014 Ending:

Summary B

12/31/2014

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	0	66,005	0	0	0	0	0	0	0	0	0	66,005	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,530)	117,333	0	0	0	0	0	0	0	0	0	113,803	32
33	Real Estate Taxes	0	(38,088)	0	0	0	0	0	0	0	0	0	(38,088)	33
34	Rent-Facility & Grounds	0	(945,000)	0	0	0	0	0	0	0	0	0	(945,000)	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	(3,530)	(799,750)	0	(803,280)	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)	(135,051)	(787,045)	0	0	0	0	0	0	0	0	0	(922,096)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
CHARLOTTE KOHN	99%	BIRCHWOOD PLAZA INC	CHICAGO, IL	DOBSON PLAZA INC		REAL ESTATE
ARTHUR J KOHN	1%				EVANSTON	RENTAL

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	34 RENT	\$ 945,000	DOBSON PLAZA INC		\$	\$ (945,000)	1
2	V	30 SL DEPRECIATION		" "		66,005	66,005	2
3	V	32 INTEREST		" "		117,333	117,333	3
4	V	33 2010 REAL ESTATE TAX REFUND	38,088	" "			(38,088)	4
5	V	19 REAL ESTATE TAX-LEGAL		" " REIFF SCHRAMM & KANTER		12,705	12,705	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		\$ 983,088			\$ 196,043	\$ * (787,045)	14

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

Facility Name & ID Number DOBSON PLAZA # 0051508 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	99.00	90,000	33	55.00	SALARY	\$ 110,000	17-1	1
2	BARAK KOHN	BUILDING ADMIN	SUPERVISION	0.00	10,953	18	72.00	SALARY	28,577	17-1	2
3	REBECCA KOHN	ADMIN CONSULT	CONSULTANT	0.00	41,162	6	50.00	SALARY	43,712	17-1	3
4											4
5											5
6											6
7											7
8											8
9	BY ATTRIBUTION, 100% KOHN FAMILY OWNED										
10											10
11	CERTAIN AMOUNTS ON THIS PAGE HAVE BEEN ADJUSTED TO REFLECT EXPECTED IL DEPT OF HFS ALLOWABLE LIMITATIONS										
12											12
13								TOTAL	\$ 182,289		13

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

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

Facility Name & ID Number DOBSON PLAZA

0051508 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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

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

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

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

0051508

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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		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	RELATED PARTY - DOBSON PLAZA INC:						\$	\$		\$	1						
2	MB FINANCIAL		X	MORTGAGE	\$32,880.35	12/16/04	5,500,000	3,333,410	12/05/19	3.2500	114,836						
3	NATIONAL REPUBLIC BANK		X	LINE OF CREDIT	DEMAND		230,000			PRIME+	2,497						
4											4						
5											5						
Working Capital																	
6											6						
7											7						
8											8						
9	TOTAL Facility Related				\$32,880.35		\$ 5,730,000	\$ 3,333,410		\$ 117,333	9						
B. Non-Facility Related*																	
10	MISC		X	LATE FEES							734						
11											11						
12											12						
13											13						
14	TOTAL Non-Facility Related						\$	\$		\$ 734	14						
15	TOTALS (line 9+line14)						\$ 5,730,000	\$ 3,333,410		\$ 118,067	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

* 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 2013 report.		\$	207,220		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.)		\$	223,708		2
3. Under or (over) accrual (line 2 minus line 1).		\$	16,488		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	225,950		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.)		\$	12,705		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 \$ 38,088 For 2010 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(38,088)		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	217,055		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	149,761	8	FOR BHF USE ONLY	
	2010	194,850	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	195,834	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	205,168	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	223,708	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL					
THE PAYMENT ON LINE 2 APPLIES TO THE 2013 TAX BILL.					

NOTES:

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

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

0051508 Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RELATED PARTY - DOBSON PLAZA INC:</u>			\$	1
2	<u>NURSING HOME</u>	<u>7,728</u>	<u>1966</u>	<u>80,509</u>	2
3	TOTALS	<u>7,728</u>		\$ <u>80,509</u>	3

Facility Name & ID Number DOBSON PLAZA

0051508

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		RELATED PARTY-DOBSON PLAZA INC:			\$	\$		\$	\$	\$	4
5	58		1966	1966	251,171		35			251,171	5
6	33			1987	930,705	38,099	40	23,268	(14,831)	637,429	6
7	2			1971	11,147		8-12			11,147	7
8	4			1987	64,011		30	1,067	1,067	13,871	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	38	38	5,650	14
15		LAND IMPROVEMENTS - FENCING		1988	1,878		15			1,878	15
16		LAND IMPROVEMENTS - PAVING		1988	12,335		20			12,335	16
17		OUTSIDE SIGN		1988	2,473		12			2,473	17
18		SPRINKLER SYSTEM		1988	42,241		25	273	273	42,241	18
19		HEATING, VENTILATION, & A/C		1988	48,620		20			48,620	19
20		PLUMBING COMPOSITE		1988	63,062		25			63,062	20
21		ELECTRICAL WIRING		1988	115,484		20			115,484	21
22		BRICK-ENCLOSED GENERATOR		1989	1,375		25	55	55	1,348	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)	240,732	25
26		CANOPY SIGN		1999	8,000	205	39	205		3,152	26
27		ELEVATOR REPAIR		1999	1,990	51	39	51		776	27
28		FIRE DAMPERS / AIR INTAKES		2000	10,515	382	27.5	382		5,587	28
29		ELEVATOR UPGRADE / AIR INTAKES		2000	28,259	1,028	27.5	1,028		14,521	29
30		ELEVATOR UPGRADE		2001	18,977	690	27.5	690		9,516	30
31		CARPETING		2001	25,597		10			25,597	31
32		HEAT EXCHANGER / FIRE SUPPRESSION SYSTEM		2003	11,572	421	27.5	421		4,938	32
33		HYDRAULIC ELEVATOR PUMP		2006	10,772	392	27.5	392		3,446	33
34		BATHRM FIXTURES/LIGHTG/CARPENTRY/RAILS/WALLPAPER		2006	29,463	1,071	27.5	1,071		9,210	34
35		NURSG STN/BATHRMS/PLUMBG/FLOORING/ROOF FASCIA		2007	53,627	1,950	27.5	1,950		14,705	35
36		BEAUTY SHOP DRYWALL,CABINETRY,PLUMBING,TILE		2007	7,287	265	27.5	265		1,844	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

Facility Name & ID Number DOBSON PLAZA

0051508

Report Period Beginning:

01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 2,107	37
38	PT, AAD, DAYRMS- DRYWALL, FLOORING, STUDS, JOIST	2008	19,380	705	27.5	705		4,788	38
39	BATHRMS: TILE, FLOOR, DRYWALL, PAINT, PAPER, FIXTURE	2008	15,425	561	27.5	561		3,724	39
40	REPIPE KITCHEN WATER LINES	2008	2,065	75	27.5	75		505	40
41	FOOD SERVICE COUNTER/CABINET / FLOORING	2008	3,015	109	27.5	109		715	41
42	LOWER LEVEL: REMOVE DOOR, WALL & BATHRM/ ENLARGE ROOM & ADD NEW BATHROOM/ DRYWALL/ SOFFIT/ WALLPAPER/ PAINT/ FIXTURES/ HANDICAP ACCESIBILITY	2008	38,800	1,411	27.5	1,411		8,658	42
43	& NURSING STATION BUILT-IN CABINETS/COUNTER TO	2008	18,500	673	27.5	673		4,122	43
44	ROOF	2008	11,259	770	10	1,126	356	7,885	44
45	CARPETING	2008	18,807	1,254	15	1,254		8,150	45
46	DRIVEWAY/PARKING LOT	2009	5,530	201	27.5	201		1,189	46
47	THERAPY ROOM WALL/SHELVING/CARPENTRY/6 DOORS	2009	12,325	448	27.5	448		2,546	47
48	ROOF/5-TON AC CONDENSER/WINDOWS	2009	5,671	206	27.5	206		1,166	48
49	SECURITY SYSTEM/CABLES/WANDERGUARD WIRING	2009	7,975	290	27.5	290		1,535	49
50	CARPENTRY/RECESSED LIGHTING/WIRING 28 OUTLETS	2009	3,700	135	27.5	135		716	50
51	SUMP PUMP MOTOR & PIPELINES	2009	2,919	108	27.5	108		545	51
52	CERAMIC FLOOR/CARPENTRY/CLOSET/INTERCOM/CABL	2009	13,299	1,277	10	1,330	53	7,315	52
53	CARPETING/WINDOW TREATMENTS/WALLPAPER	2010	8,730	317	27.5	317		1,519	53
54	OUTLETS/CABLE/WALL MOUNTS	2010	5,911	215	27.5	215		1,048	54
55	NURSING STATION BUILT-INS/ DRYWALL/ SINK/ COUNTER	2010	3,868	141	27.5	141		652	55
56	DELAYED ELEVATOR EGRESS LOCKS	2010	12,741	2,038	10	1,274	(764)	5,733	56
57	WALLPAPER/ CARPETING/ COVE BASE/ BASEBOARDS	2010	7,719	281	27.5	281		1,183	57
58	SUMP PUMP	2011	5,119		10	512	512	1,792	58
59	WEIL PUMP 2224								59
60	2ND FL NURSING STATION / CARPENTRY / BUILT-INS / CLOSET / RAILS / VINYL FLOORING:								60
61		2011	5,647	205	27.5	205		760	61
62	1ST FL NURSING STATION SOCKETS/LIGHTING/BUILT-IN KITCHEN CABINETS/BATHROOM TILEWORK, PIPING, DRYWALL/LIBRARY DUCTWORK & VENTS/WALLPAPER/								62
63	& SEAL WINDOWS/1ST FL BATHROOM DEMOLITION-NEW DRYWALL/SOFFITS/CONCRETE/PLUMBING/ELECTRIC/TILING/FIXTURES/PRIME/PAINT/FLOORING/THERAPY								63
64	ROOM FLOORING	2012	50,751	1,845	27.5	1,845		4,536	64
65	A/C FOR DINING ROOM	2012	3,120	113	27.5	113		278	65
66	WIRING	2014	5,597	127	27.5	127		127	66
67									67
68	ADJUST TO STRAIGHT LINE			(16,047)			16,047		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,616,920	\$ 58,498		\$ 58,498	\$	\$ 1,643,474	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 58,291	\$ 6,737	\$ 6,737	\$	8-10 YRS	\$ 28,156	71
72	Current Year Purchases	12,315	770	770		8 YRS	770	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 70,606	\$ 7,507	\$ 7,507	\$		\$ 28,926	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMIN, BANKING,	'07 LEXUS RX400H	2006	\$ 58,079	\$	\$	\$	4 YRS	\$ 58,079	76
77	ACTIVITIES,MAINT,									77
78	& PURCHASING,ETC									78
79										79
80	TOTALS			\$ 58,079	\$	\$	\$		\$ 58,079	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)	\$ 2,826,114	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,005	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,005	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,730,479	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A - RELATED PARTY**

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ **0** 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			\$	\$ 0	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	95,352	\$		\$	95,352	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				29,736				29,736	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				274,850				274,850	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					97,448			97,448	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						22,105			22,105	13
14	TOTAL			\$		\$	399,938	\$	119,553	\$	519,491	14

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

Facility Name & ID Number **DOBSON PLAZA**# **0051508**Report Period Beginning: **01/01/2014**

Ending:

12/31/2014**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2014**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 253,310	\$ 542,687	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,660,055	1,660,055	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		542,144	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	61,385	95,997	7
8	Accounts Receivable (owners or related parties)		853,966	8
9	Other(specify): DUE TO DOBSON PLAZA INC	893,013		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,867,763	\$ 3,694,849	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		566,641	15
16	Equipment, at Historical Cost		128,684	16
17	Accumulated Depreciation (book methods)		(1,880,975)	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	299,966	299,966	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 299,966	\$ 1,277,106	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,167,729	\$ 4,971,955	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 105,938	\$ 105,938	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	92,966	92,966	29
30	Accrued Salaries Payable	97,630	97,630	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,728	9,728	31
32	Accrued Real Estate Taxes(Sch.IX-B)		225,950	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 306,262	\$ 532,212	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,333,410	40
41	Bonds Payable			41
42	Deferred Compensation	992,617	992,617	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 992,617	\$ 4,326,027	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,298,879	\$ 4,858,239	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,868,850	\$ 113,716	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,167,729	\$ 4,971,955	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 992,420	1
2	Restatements (describe):		2
3			3
4	IL REPLACEMENT TAX	(13,770)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 978,650	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	890,200	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	()	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)	\$ 890,200	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)	\$ 1,868,850	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,661,462	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,661,462	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	273,108	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 273,108	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***	2,796	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,796	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)	\$ 6,937,366	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	696,762	31
32	Health Care	2,264,760	32
33	General Administration	1,141,909	33
B. Capital Expense			
34	Ownership	1,192,230	34
C. Ancillary Expense			
35	Special Cost Centers	520,347	35
36	Provider Participation Fee	231,158	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,047,166	40
41	Income before Income Taxes (line 30 minus line 40)**	890,200	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 890,200	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,549,104	44
45	Private Pay - Net Inpatient Revenue	2,518,167	45
46	Medicare - Net Inpatient Revenue	1,211,468	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	382,723	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,661,462	49

****TAX RETURN PREPARED ON CASH BASIS**

- * This must agree with page 4, line 45, column 4.
- ** Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.
- *** 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**

0051508

Report Period Beginning: **01/01/2014**

Ending:

12/31/2014

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	1,981	2,197	\$ 103,735	\$ 47.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,048	23,628	760,419	32.18	3
4	Licensed Practical Nurses	2,105	2,437	173,207	71.07	4
5	CNAs & Orderlies	54,472	61,358	737,376	12.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,991	2,310	41,033	17.76	9
10	Activity Assistants	3,697	3,751	50,598	13.49	10
11	Social Service Workers	1,122	1,256	27,057	21.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,745	3,106	35,280	11.36	14
15	Cook Helpers/Assistants	7,667	8,417	77,736	9.24	15
16	Dishwashers					16
17	Maintenance Workers	4,236	4,918	58,946	11.99	17
18	Housekeepers	4,467	4,936	49,585	10.05	18
19	Laundry	3,028	3,421	32,003	9.35	19
20	Administrator	2,086	2,086	183,494	87.96	20
21	Assistant Administrator					21
22	Other Administrative	1,534	1,534	72,289	47.12	22
23	Office Manager					23
24	Clerical	4,509	5,097	101,211	19.86	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	2,822	2,982	81,062	27.18	31
32	Other Health C: ADMIT/QA/MDS	4,173	4,173	143,798	34.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,683	137,607	\$ 2,728,829 *	\$ 19.83	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	\$ 57,514	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	4,616	10-3	37
38	Nurse Consultant	T	9,500	10-3	38
39	Pharmacist Consultant	H	0	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)		\$ 87,470		49

C. CONTRACT NURSES

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number DOBSON PLAZA

0051508

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. \$ 14,130 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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
DOBSON PLAZA INC #0008136 07/01/2011
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 231,158
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? YES 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. \$ 11,315 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.