

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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.

I. IDPH Facility ID Number: 0044321

Facility Name: DeKalb County Rehab & Nursing

Address: 2600 North Annie Glidden Road DeKalb 60115
 Number City Zip Code

County: DeKalb

Telephone Number: (815) 758-2477 **Fax #** (815) 758-3176

HFS ID Number: 366006548003

Date of Initial License for Current Owners: 07/15/1954

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" 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 checked="" type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Patricia C. Anderson **Telephone Number:** (815) 758-2477 Ext: 161

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2004 to 11/30/2005 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Catherine Anderson</u>	
	(Title) <u>Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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

Facility Name & ID Number DeKalb County Rehab & Nursing# 0044321 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

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 12/30/2004

	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>194</u>	Skilled (SNF)	<u>190</u>	<u>69,466</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>194</u>	TOTALS	<u>190</u>	<u>69,466</u>	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	<u>691</u>	<u>52</u>	<u>6,058</u>	<u>6,801</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>32,198</u>	<u>26,302</u>		<u>58,500</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,889</u>	<u>26,354</u>	<u>6,058</u>	<u>65,301</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.00%

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)

Outpatient therapyF. 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 03/09/2000

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

YES Date 03/09/2000 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 194 and days of care provided 366Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: _____ Fiscal Year: Tax exempt

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

Facility Name & ID Number DeKalb County Rehab & Nursing # 0044321 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	479,887	46,268	23,833	549,988		549,988		549,988			1
2	Food Purchase		423,637		423,637		423,637	(4,607)	419,030			2
3	Housekeeping	208,438	40,189	1,816	250,443		250,443		250,443			3
4	Laundry	67,288	9,625	122,732	199,645		199,645		199,645			4
5	Heat and Other Utilities			309,142	309,142		309,142	(13,814)	295,328			5
6	Maintenance	88,578	43,818	47,566	179,962		179,962		179,962			6
7	Other (specify):* waste mgmt,pest&paper elim			30,128	30,128		30,128		30,128			7
8	TOTAL General Services	844,191	563,537	535,217	1,942,945		1,942,945	(18,421)	1,924,524			8
	B. Health Care and Programs											
9	Medical Director			5,020	5,020		5,020		5,020			9
10	Nursing and Medical Records	3,903,882	260,776	267,643	4,432,301		4,432,301		4,432,301			10
10a	Therapy	172,782	6,065	459,572	638,419		638,419	(70,255)	568,164			10a
11	Activities	105,321	10,912	8,251	124,484		124,484		124,484			11
12	Social Services	139,362	26	2,848	142,236		142,236		142,236			12
13	CNA Training											13
14	Program Transportation		4,584		4,584		4,584		4,584			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,321,347	282,363	743,334	5,347,044		5,347,044	(70,255)	5,276,789			16
	C. General Administration											
17	Administrative	120,141		85,829	205,970		205,970		205,970			17
18	Directors Fees											18
19	Professional Services			9,392	9,392		9,392		9,392			19
20	Dues, Fees, Subscriptions & Promotions			30,631	30,631		30,631	(2,492)	28,139			20
21	Clerical & General Office Expenses	150,698	24,680	97,265	272,643		272,643		272,643			21
22	Employee Benefits & Payroll Taxes			1,532,936	1,532,936		1,532,936		1,532,936			22
23	Inservice Training & Education			14,833	14,833		14,833		14,833			23
24	Travel and Seminar			11,990	11,990		11,990		11,990			24
25	Other Admin. Staff Transportation			2,437	2,437		2,437		2,437			25
26	Insurance-Prop.Liab.Malpractice			26,800	26,800		26,800		26,800			26
27	Other (specify):*											27
28	TOTAL General Administration	270,839	24,680	1,812,113	2,107,632		2,107,632	(2,492)	2,105,140			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,436,377	870,580	3,090,664	9,397,621		9,397,621	(91,168)	9,306,453			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.

Facility Name & ID Number DeKalb County Rehab & Nursing #0044321 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			622,478	622,478		622,478	(39,474)	583,004			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			345,138	345,138		345,138	(168,363)	176,775			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			50,498	50,498		50,498		50,498			35
36	Other (specify):* loss on disposal F/A			2,121	2,121		2,121		2,121			36
37	TOTAL Ownership			1,020,235	1,020,235		1,020,235	(207,837)	812,398			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,628	1,628		1,628		1,628			38
39	Ancillary Service Centers		148,961		148,961		148,961		148,961			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,199	104,199		104,199		104,199			42
43	Other (specify):* Lab& xray fees			16,645	16,645		16,645		16,645			43
44	TOTAL Special Cost Centers		148,961	122,472	271,433		271,433		271,433			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,436,377	1,019,541	4,233,371	10,689,289		10,689,289	(299,005)	10,390,284			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 DeKalb County Rehab & Nursing

0044321

Report Period Beginning: 12/01/2004

Ending: 11/30/2005

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients	(70,255)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,607)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,814)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(39,474)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				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	(1,710)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(782)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,642)		\$	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))	\$ (130,642)		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.

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$ 1,628	V38.3	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology		x	16,645	V43.3	42
43	Prescription Drugs		x	148,961	V39.2	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 167,234		47

OHF USE ONLY						
48		49		50		51
						52

DeKalb County Rehab & Nursing

ID# 0044321

Report Period Beginning: 12/01/2004

Ending: 11/30/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DeKalb County Rehab & Nursing

0044321

Report Period Beginning:

12/01/2004

Ending:

11/30/2005

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,607)	0	0	0	0	0	0	0	0	0	0	(4,607)	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	(13,814)	0	0	0	0	0	0	0	0	0	0	(13,814)	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	(18,421)	0	0	0	0	0	0	0	0	0	0	(18,421)	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	(70,255)	0	0	0	0	0	0	0	0	0	0	(70,255)	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	(70,255)	0	0	0	0	0	0	0	0	0	0	(70,255)	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	(2,492)	0	0	0	0	0	0	0	0	0	0	(2,492)	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,492)	0	0	0	0	0	0	0	0	0	0	(2,492)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(91,168)	0	0	0	0	0	0	0	0	0	0	(91,168)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DeKalb County Rehab & Nursing

0044321

Report Period Beginning:

12/01/2004 Ending:

11/30/2005

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(39,474)	0	0	0	0	0	0	0	0	0	0	(39,474)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	(39,474)	0	(39,474)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(130,642)	0	(130,642)	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
DeKalb County Government	100					

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	22 Fica Taxes	\$ 399,805	DeKalb County Government	100.00%	\$ 399,805	\$
2	V	22 IMRF	305,623	DeKalb County Government	100.00%	305,623	
3	V	22 Workers Compensation	36,864	DeKalb County Government	100.00%	36,864	
4	V	21 Chargeback	62,000	DeKalb County Government	100.00%	62,000	
5	V	22 Workers Comp. Excess Policy	5,000	DeKalb County Government	100.00%	5,000	
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 809,292			\$ 809,292	\$ *

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

Facility Name & ID Number DeKalb County Rehab & Nursing # 0044321 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 DeKalb County Rehab & Nursing

0044321

Report Period Beginning: 12/01/2004

Ending: 1/30/2005

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

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**					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	Bond	x					\$	\$		0.0520	\$ 345,138	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$	\$			\$ 345,138	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$	\$			\$ 345,138	15				

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DeKalb County Rehab & Nursing COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0044321

CONTACT PERSON REGARDING THIS REPORT Patricia Anderson

TELEPHONE (815) 758-2477 ext:161 FAX #: (815) 758-3176

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ tax exempt	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 81,992 B. General Construction Type: Exterior Brick & Vinyl Frame wood & metal Number of Stories 1

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).

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: 89,666 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: 03/09/2000

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>243,065</u>	<u>1998</u>	<u>\$ 83,098</u>	1
2					2
3	TOTALS	243,065		\$ 83,098	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	190		2000	2000	\$ 10,887,894	\$ 474,990	25	\$ 435,516	\$ (39,474)	\$ 2,502,052	4
5			2000	2000	117,663	4,707	25	4,707		27,061	5
6											6
7											7
8											8
	Improvement Type**										
9		Construction cost to new building since 3/9/00 Cap. Rpt		1999	12,293	800	10 to 20	800		5,118	9
10		Construction cost to new building since 3/9/00 Cap. Rpt		2000	10,553	654	15 to 25	654		3,768	10
11		Cost to new building since 3/9/00 Cap. Rpt.		2000	37,957	2,157	10 to 25	2,157		11,473	11
12		Maint. Building see fac. Letter and OHF rpt. 4/23 & 6/18/01		2000	109,759	5,488	20	5,488		26,068	12
13		Electric, Acoustical duct repair, seal coat, dry wall		2001	21,598	1,424	5 to 24	1,424		6,683	13
14		Half gate, work station, swing door, gazebo & concrete		2001	63,940	4,219	15 to 20	4,219		18,728	14
15		Duct repair,dumpster slab,stainless steel in kitchen, architect p		2002	10,421	919	5 to 25	919		3,599	15
16		Employee entrance & courtyard landscaping		2003	11,355	1,135	10	1,135		2,638	16
17		Improve locks on doors,stainless steel walls dietary, lot lights,		2004	30,177	2,504	6 to 15	2,504		1,756	17
18		Maint. Mezzanine,replace fire system,upgrade fire lane,compres		2005	24,617	1,125	5 to 20	1,125		1,125	18
19		Architect,programming,construction, adm., painting, dementia unit		2005	339,823	2,832	20	2,832		2,832	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

*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 DeKalb County Rehab & Nursing

0044321

Report Period Beginning:

12/01/2004

Ending:

11/30/2005

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 11,678,050	\$ 502,954		\$ 463,480	\$ (39,474)	\$ 2,612,901	70

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

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	\$ 1,051,781	\$ 108,264	\$ 108,264	\$	5 to 15	\$ 972,395	71
72	Current Year Purchases	83,041	5,044	5,044		4 to 15	5,044	72
73	Fully Depreciated Assets	(325,586)	5,420	5,420		5 to 15		73
74	Retired Equipment	(20,156)	796	796		5 to 10	(18,035)	74
75	TOTALS	\$ 789,080	\$ 119,524	\$ 119,524	\$		\$ 959,404	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	Patient Activities	Ford - Bus	1989	\$ 38,695	\$	\$	\$	8	\$ 38,695	76
77	Maintenance	GMC 1995 Truck	1996	22,383				5	22,383	77
78										78
79										79
80	TOTALS			\$ 61,078	\$	\$	\$		\$ 61,078	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)	\$ 12,611,306	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 622,478	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 583,004	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (39,474)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,633,383	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	Courtyard Pond - CIP	\$ 1,352	92
93	Sr. Living Facility - CIP	18,321	93
94			94
95		\$ 19,673	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: _____

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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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

* 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>
--	---	--

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	10a-3	hrs	\$	1,604	\$ 107,008	\$	1,604	\$ 107,008	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,191	18,522		1,191	18,522	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		4,868	334,042		4,868	334,042	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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	7,663	\$ 459,572	\$	7,663	\$ 459,572	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 DeKalb County Rehab & Nursing# 0044321Report Period Beginning: 12/01/2004

Ending:

11/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2005

(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	\$ 303,866	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (39,387))	1,909,947		3
4	Supply Inventory (priced at <u>cost</u>)	11,834		4
5	Short-Term Investments	2,506,377		5
6	Prepaid Insurance	56,716		6
7	Other Prepaid Expenses	9,328		7
8	Accounts Receivable (owners or related parties)	2,107,000		8
9	Other(specify): <u>Accrued Interest</u>	7,520		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,912,588	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,098		13
14	Buildings, at Historical Cost	11,005,557		14
15	Leasehold Improvements, at Historical Cost	672,492		15
16	Equipment, at Historical Cost	1,525,866		16
17	Accumulated Depreciation (book methods)	(3,818,853)		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 (spe Ctyd Pond-CIP	1,352		22
23	Other(specify): <u>Sr. Facility-CIP</u>	18,321		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,487,833	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,400,421	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 806,831	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	274,789		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	(8,730)		33
34	Deferred Compensation	188,857		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)	\$ 1,261,747	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,639,138		41
42	Deferred Compensation	328,720		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,967,858	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,229,605	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,170,816	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,400,421	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,070,941	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,070,941	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	131,316	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	289,848	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(345,138)	13
14	Donated Property, Plant, and Equipment	4,396	14
15	Other (describe) Inc prepd insurance & other prepd	17,513	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 97,935	17
B. Transfers (Itemize):			
18	Trfr from H.D & Finance	1,940	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,940	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,170,816	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,991,954	1
2	Discounts and Allowances for all Levels	(4,456,619)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,535,335	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	70,255	5
6	Therapy	1,123,431	6
7	Oxygen	99,862	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,293,548	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	4,607	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	199,846	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,767	19
20	Radiology and X-Ray	8,053	20
21	Other Medical Services	320,455	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 543,728	23
D. Non-Operating Revenue			
24	Contributions	289,848	24
25	Interest and Other Investment Income***	168,363	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 458,211	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Loss on Bad Debt & Prior year revenue	(20,023)	28
28a	Maint., w/c reimb., misc., donation F/a	9,806	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (10,217)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,820,605	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,942,945	31
32	Health Care	5,347,044	32
33	General Administration	2,107,632	33
B. Capital Expense			
34	Ownership	1,020,235	34
C. Ancillary Expense			
35	Special Cost Centers	167,234	35
36	Provider Participation Fee	104,199	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,689,289	40
41	Income before Income Taxes (line 30 minus line 40)**	131,316	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 131,316	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 DeKalb County Rehab & Nursing

0044321

Report Period Beginning: 12/01/2004

Ending:

11/30/2005

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	1,794	1,980	\$ 68,084	\$ 34.39	1
2	Assistant Director of Nursing	1,682	1,829	52,607	28.76	2
3	Registered Nurses	47,494	53,538	1,520,695	28.40	3
4	Licensed Practical Nurses	4,155	7,651	157,675	20.61	4
5	CNAs & Orderlies	134,975	148,567	1,991,090	13.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,915	8,612	136,229	15.82	8
9	Activity Director	1,775	2,015	34,541	17.14	9
10	Activity Assistants	12,505	14,499	128,206	8.84	10
11	Social Service Workers	7,277	8,090	139,362	17.23	11
12	Dietician	1,752	2,015	42,818	21.25	12
13	Food Service Supervisor	957	1,708	26,637	15.60	13
14	Head Cook	2,012	2,083	28,089	13.48	14
15	Cook Helpers/Assistants	4,714	5,320	60,741	11.42	15
16	Dishwashers	34,763	37,685	319,315	8.47	16
17	Maintenance Workers	4,647	5,127	88,578	17.28	17
18	Housekeepers	19,869	22,185	208,438	9.40	18
19	Laundry	7,572	7,969	67,288	8.44	19
20	Administrator	2,052	2,080	70,475	33.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,738	2,015	49,666	24.65	23
24	Clerical	10,889	11,957	150,698	12.60	24
25	Vocational Instruction	694	1,173	34,948	29.79	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					31
32	Other Health C: <u>Dr. CVS</u>	1,821	2,015	60,197	29.87	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	312,052	350,113	\$ 5,436,377 *	\$ 15.53	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	553	\$ 23,833	1-3	35
36	Medical Director	11	6,000	10-3	36
37	Medical Records Consultant	251	5,020	10-3	37
38	Nurse Consultant	50	3,511	10-3	38
39	Pharmacist Consultant		5,105	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	3,089	11-3	44
45	Social Service Consultant	54	2,848	12-3	45
46	Other(specify) <u>Dental</u>		900	10-3	46
47	<u>Utilization Review</u>	44	2,575	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,012	\$ 52,881		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	623	\$ 27,285	10-3	50
51	Licensed Practical Nurses	4,166	176,548	10-3	51
52	Certified Nurse Assistants/Aides	1,939	42,266	10-3	52
53	TOTAL (lines 50 - 52)	6,728	\$ 246,099		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? AFSCME Local#31
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Life Services & Co. N H Assoc. \$10,550
- (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? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 73,817 Line V 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. \$ 104,199
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. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 4,607
- (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? 90%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sikich Gardner & Co. LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not yet available
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.