

Facility Name & ID Number DeKalb County Rehab & Nursing# 0044321 Report Period Beginning: 12/01/2005 Ending: 11/30/2006

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>190</u>	Skilled (SNF)	<u>190</u>	<u>69,350</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>190</u>	TOTALS	<u>190</u>	<u>69,350</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>981</u>	<u>660</u>	<u>479</u>	<u>2,120</u>	8
9	SNF/PED					9
10	ICF	<u>34,101</u>	<u>23,104</u>		<u>57,205</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,082</u>	<u>23,764</u>	<u>479</u>	<u>59,325</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.54%

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? yesG. 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 190 and days of care provided 365Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL 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: 12/01/2005 Ending: 11/30/2006

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	514,122	51,468	18,227	583,817		583,817		583,817		1
2	Food Purchase		419,666		419,666		419,666	(4,320)	415,346		2
3	Housekeeping	225,282	42,904	2,392	270,578		270,578		270,578		3
4	Laundry	53,393	3,702	147,658	204,753		204,753		204,753		4
5	Heat and Other Utilities			299,620	299,620		299,620	(12,475)	287,145		5
6	Maintenance	91,492	37,785	49,255	178,532		178,532		178,532		6
7	Other (specify):* waste mgmt,pest&paper elim			38,745	38,745		38,745		38,745		7
8	TOTAL General Services	884,289	555,525	555,897	1,995,711		1,995,711	(16,795)	1,978,916		8
	B. Health Care and Programs										
9	Medical Director			11,745	11,745		11,745		11,745		9
10	Nursing and Medical Records	4,213,269	277,735	214,808	4,705,812		4,705,812		4,705,812		10
10a	Therapy	187,338	6,494	509,767	703,599		703,599	(41,197)	662,402		10a
11	Activities	129,424	13,018	8,863	151,305		151,305		151,305		11
12	Social Services	144,536		2,573	147,109		147,109		147,109		12
13	CNA Training										13
14	Program Transportation		4,816		4,816		4,816		4,816		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,674,567	302,063	747,756	5,724,386		5,724,386	(41,197)	5,683,189		16
	C. General Administration										
17	Administrative	120,623		90,681	211,304		211,304		211,304		17
18	Directors Fees										18
19	Professional Services			14,503	14,503		14,503		14,503		19
20	Dues, Fees, Subscriptions & Promotions			43,096	43,096		43,096	(1,907)	41,189		20
21	Clerical & General Office Expenses	156,720	27,658	103,149	287,527		287,527		287,527		21
22	Employee Benefits & Payroll Taxes			1,669,086	1,669,086		1,669,086		1,669,086		22
23	Inservice Training & Education			3,903	3,903		3,903		3,903		23
24	Travel and Seminar			24,168	24,168		24,168		24,168		24
25	Other Admin. Staff Transportation			2,623	2,623		2,623		2,623		25
26	Insurance-Prop.Liab.Malpractice			27,771	27,771		27,771		27,771		26
27	Other (specify):* County Contribu.			250,539	250,539		250,539		250,539		27
28	TOTAL General Administration	277,343	27,658	2,229,519	2,534,520		2,534,520	(1,907)	2,532,613		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,836,199	885,246	3,533,172	10,254,617		10,254,617	(59,899)	10,194,718		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: 12/01/2005 Ending: 11/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			615,249	615,249		615,249	(39,474)	575,775			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			324,527	324,527		324,527	(199,742)	124,785			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			63,501	63,501		63,501		63,501			35
36	Other (specify):*			12,798	12,798		12,798		12,798			36
37	TOTAL Ownership			1,016,075	1,016,075		1,016,075	(239,216)	776,859			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,468	1,468		1,468		1,468			38
39	Ancillary Service Centers		176,759		176,759		176,759		176,759			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):* lab & xray service			12,202	12,202		12,202		12,202			43
44	TOTAL Special Cost Centers		176,759	117,695	294,454		294,454		294,454			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,836,199	1,062,005	4,666,942	11,565,146		11,565,146	(299,115)	11,266,031			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: 12/01/2005

Ending: 11/30/2006

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	(41,197)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,320)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,475)	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				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	(1,082)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(825)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (59,899)		\$	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))	\$ (59,899)		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	\$ 1,468	V38.3	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology		x	12,202	V43.3	42
43	Prescription Drugs		x	153,346	V39.2	43
44	Exceptional Care Program					44
45	Other-Attach Schedule <u>Oxygen</u>		x	23,413	V39.2	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 190,429		47

BHF USE ONLY						
48		49		50		51
						52

DeKalb County Rehab & Nursing

ID# 0044321

Report Period Beginning: 12/01/2005

Ending: 11/30/2006

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:

12/01/2005

Ending:

11/30/2006

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	(4,320)	0	0	0	0	0	0	0	0	0	0	(4,320)	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	(12,475)	0	0	0	0	0	0	0	0	0	0	(12,475)	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	(16,795)	0	0	0	0	0	0	0	0	0	0	(16,795)	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	(41,197)	0	0	0	0	0	0	0	0	0	0	(41,197)	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	(41,197)	0	0	0	0	0	0	0	0	0	0	(41,197)	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	(1,907)	0	0	0	0	0	0	0	0	0	0	(1,907)	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	(1,907)	0	0	0	0	0	0	0	0	0	0	(1,907)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(59,899)	0	0	0	0	0	0	0	0	0	0	(59,899)	29

STATE OF ILLINOIS

Facility Name & ID Number DeKalb County Rehab & Nursing

0044321

Report Period Beginning:

12/01/2005 Ending:

Summary B

11/30/2006

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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)	(59,899)	0	(59,899)	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	\$ 451,082	DeKalb County Government	100.00%	\$ 451,082	\$ 1
2	V	22 IMRF	373,956	DeKalb County Government	100.00%	373,956	2
3	V	22 Health Insurance	745,828	DeKalb County Government	100.00%	745,828	3
4	V	22 Workers Compensation	40,299	DeKalb County Government	100.00%	40,299	4
5	V	21 Chargeback	62,000	DeKalb County Government	100.00%	62,000	5
6	V	22 Workers Comp. Excess Policy	5,000	DeKalb County Government	100.00%	5,000	6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 1,678,165			\$ 1,678,165	\$ * 14

* 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: 12/01/2005 Ending: 11/30/2006

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: 12/01/2005

Ending: 1/30/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bond	x						0.0520	\$ 324,527	1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$ 324,527	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$ 324,527	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.)

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 2005 report.		\$	<u>tax exempt</u>	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.)		\$	<u>tax exempt</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>#VALUE!</u>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>#VALUE!</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	_____	8	
	2002	_____	9	
	2003	_____	10	
	2004	_____	11	
	2005	_____	12	
			FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 2005 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 2005.

(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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

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	2	3	4	5	6	7	8	9	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	190	2000	2000	\$ 10,887,894	\$ 474,989	25	\$ 435,516	\$ (39,473)	\$ 2,937,568	4
5		2000	2000	117,663	4,707	25	4,707		31,769	5
6										6
7										7
8										8
	Improvement Type**									
9	Construction Cap. Rpt cost - new building 3/9/00		1999	12,293	800	10 to 20	800		5,918	9
10	Construction Cap. Rpt cost - new building 3/9/00		2000	10,553	654	15 to 25	654		4,422	10
11	Cap. Rpt. Costs - new building since 3/9/00		2000	37,957	2,157	10 to 25	2,157		13,630	11
12	Maint. Building see fac. Letter and OHF rpt 6/18/01		2000	109,759	5,488	20	5,488		31,556	12
13	Electric,Acoustical duct repair,seal coat dry wall		2001	21,598	1,054	5 to 24	1,054		7,737	13
14	Half gate,workstation,swing door,gazebo, & concrete		2001	63,940	4,219	15 to 20	4,219		22,947	14
15	Duct repair,dumpster,slab,stainless steel-kitchen,		2002	10,421	919	5 to 25	919		4,518	15
16	Employee entrance & courtyard landscaping		2003	11,355	1,135	10	1,135		3,773	16
17	Locks on doors, stainless steel walls dietary,lot lights		2004	30,177	2,804	6 to 15	2,804		7,527	17
18	Maint. Mezzanine, replace fire system, fire lane, compressor		2005	24,617	2,775	5 to 20	2,775		3,900	18
19	Architect,construction,painting,programming, dementia unit		2005	339,823	29,700	20	29,700		32,532	19
20	Mirror,painting,replace concrete CVS,replace 29 sprinklers		2006	9,978	415	5 to 18	415		415	20
21	Replace 2 doors, add magnets, install magnets & smoke detectors		2006	13,813	179	5	179		179	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:

12/01/2005 Ending:

11/30/2006

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)	\$ 11,701,841	\$ 531,995		\$ 492,522	\$ (39,473)	\$ 3,108,391	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	\$ 1,134,822	\$ 74,197	\$ 74,197	\$	5 to 15	\$ 1,046,592	71
72	Current Year Purchases	98,468	5,155	5,155		5 to 15	5,155	72
73	Fully Depreciated Assets	(393,645)	2,485	2,485		5 to 15		73
74	Retired Equipment	(72,213)	1,416	1,416		5 to 15	(54,732)	74
75	TOTALS	\$ 767,432	\$ 83,253	\$ 83,253	\$		\$ 997,015	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)		\$ 12,613,449	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 615,248	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 575,775	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (39,473)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 4,166,484	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	Sr. Living Facility - CIP	\$ 45,507	92
93			93
94			94
95		\$ 45,507	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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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	\$	7,241	\$ 118,469	\$	7,241	\$ 118,469	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		718	22,239		718	22,239	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		17,731	298,766		17,731	298,766	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			153,346			153,346	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Oxygen</u>	39.2					23,413		23,413	13
14	TOTAL			\$	25,690	\$ 592,820	\$ 23,413	25,690	\$ 616,233	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: 12/01/2005

Ending:

11/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2006

(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	\$ 2,555,703	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 30,721)	3,144,369		3
4	Supply Inventory (priced at cost)	11,784		4
5	Short-Term Investments			5
6	Prepaid Insurance	66,035		6
7	Other Prepaid Expenses	9,428		7
8	Accounts Receivable (owners or related parties)	1,906,280		8
9	Other(specify): <u>Accrued interest</u>	5,745		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,699,344	\$	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	11,115,317		14
15	Leasehold Improvements, at Historical Cost	586,524		15
16	Equipment, at Historical Cost	1,556,010		16
17	Accumulated Depreciation (book methods)	(4,379,366)		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	3,332		22
23	Other(specify): <u>Sr. Facility-CIP</u>	45,509		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,010,424	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,709,768	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 288,480	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	437,275		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	308,249		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	83,190		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>A/P other funds</u>	450,009		36
37	<u>Reserve for Igt & W/c settlements</u>	101,681		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,660,154	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,200,388		41
42	Deferred Compensation	373,515		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,573,903	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,234,057	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,475,711	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,709,768	\$	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	<u>Decrease in allowance for doubtful accounts per auditor</u>	8,666	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,079,607	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	304,515	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	76,444	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment	4,253	14
15	Other (describe) <u>Inc prepd ins & other prepd</u>	9,370	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 394,582	17
	B. Transfers (Itemize):		
18	<u>Trfr from HD & Finance</u>	1,522	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,522	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,475,711	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number DeKalb County Rehab & Nursing# 0044321Report Period Beginning: 12/01/2005Ending: 11/30/2006**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	\$ 13,683,438	1
2	Discounts and Allowances for all Levels	(4,575,883)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,107,555	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	41,197	5
6	Therapy	1,099,987	6
7	Oxygen	137,432	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,278,616	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	4,320	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	244,101	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,556	19
20	Radiology and X-Ray	5,971	20
21	Other Medical Services	374,830	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 636,778	23
D. Non-Operating Revenue			
24	Contributions	76,443	24
25	Interest and Other Investment Income***	199,742	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 276,185	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Township Contributions	194,993	28
28a	Igt adj.,Maint.,W/c reimb.,Misc., loss on bad debt &mc	375,534	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 570,527	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,869,661	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,995,711	31
32	Health Care	5,747,799	32
33	General Administration	2,534,520	33
B. Capital Expense			
34	Ownership	1,016,075	34
C. Ancillary Expense			
35	Special Cost Centers	167,016	35
36	Provider Participation Fee	104,025	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,565,146	40
41	Income before Income Taxes (line 30 minus line 40)**	304,515	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 304,515	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: 12/01/2005

Ending:

11/30/2006

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	1,814	2,015	\$ 72,407	\$ 35.93	1
2	Assistant Director of Nursing	1,845	2,015	60,235	29.89	2
3	Registered Nurses	49,049	53,813	1,811,834	33.67	3
4	Licensed Practical Nurses	9,007	9,470	211,292	22.31	4
5	CNAs & Orderlies	128,760	138,303	1,971,040	14.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,633	7,569	122,768	16.22	8
9	Activity Director	1,780	2,015	33,790	16.77	9
10	Activity Assistants	13,790	15,063	144,976	9.62	10
11	Social Service Workers	5,360	6,046	95,308	15.76	11
12	Dietician	1,779	2,015	44,099	21.89	12
13	Food Service Supervisor	1,962	2,155	35,187	16.33	13
14	Head Cook	1,900	2,111	27,468	13.01	14
15	Cook Helpers/Assistants	5,124	5,878	67,985	11.57	15
16	Dishwashers	35,501	38,165	339,383	8.89	16
17	Maintenance Workers	4,733	5,052	91,492	18.11	17
18	Housekeepers	19,958	23,476	225,282	9.60	18
19	Laundry	7,263	7,755	53,393	6.88	19
20	Administrator	2,080	2,080	69,695	33.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,722	2,007	50,928	25.38	23
24	Clerical	10,717	11,704	156,720	13.39	24
25	Vocational Instruction	1,127	1,339	42,858	32.01	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 Care Dir. CVS	1,710	1,919	59,482	31.00	32
33	Other(specify) Social Serv. Dir.	1,914	2,015	49,228	24.43	33
34	TOTAL (lines 1 - 33)	315,528	343,980	\$ 5,836,850 *	\$ 16.97	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	419	\$ 18,227	1-3	35
36	Medical Director	12	6,000	9-3	36
37	Medical Records Consultant	287	5,745	9-3	37
38	Nurse Consultant	19	1,391	10-3	38
39	Pharmacist Consultant		5,518	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	38	2,492	11-3	44
45	Social Service Consultant	45	2,573	12-3	45
46	Other(specify) Dental		900	10-3	46
47	Utilization Review	21	2,450	10-3	47
48	Dementia Consultant	10	651	10-3	48
49	TOTAL (lines 35 - 48)	851	\$ 45,947		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	201	\$ 8,767	10-3	50
51	Licensed Practical Nurses	4,163	183,645	10-3	51
52	Certified Nurse Assistants/Aides	529	11,486	10-3	52
53	TOTAL (lines 50 - 52)	4,893	\$ 203,898		53

Facility Name & ID Number DeKalb County Rehab & Nursing

0044321

Report Period Beginning: 12/01/2005

Ending: 11/30/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Catherine Anderson	Administrator		\$ 69,695	Workers' Compensation Insurance	\$ 5,000	IDPH License Fee	\$ 1,990		
Patricia Anderson	Business Mger		50,928	Unemployment Compensation Insurance	40,299	Advertising: Employee Recruitment	15,601		
				FICA Taxes	451,082	Health Care Worker Background Check			
				Employee Health Insurance	744,552	(Indicate # of checks performed <u>118</u>)	1,232		
				Employee Meals	0	Patient Background Checks <u>393</u>	3,930		
				Illinois Municipal Retirement Fund (IMRF)*	373,956	Advertising	4,687		
				W/C Medical Expense	29,761	Bond fee	700		
				W/C Salaries	98	Memberships	11,954		
				Medical Expense	6,171	subscriptions	2,852		
				Life Insurance	18,167	Clia Fee	150		
						Less: Public Relations Expense	(0)		
						Non-allowable advertising	(1,082)		
						Yellow page advertising	(825)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 120,623	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 41,189	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Performance			\$ 90,681				Out-of-State Travel	\$	
							In-State Travel	4,915	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 90,681				Seminar Expense	19,253	
C. Professional Services									
Vendor/Payee	Type		Amount				Entertainment Expense	()	
Reingrueber & Assoc.	Accounting		2,641				(agree to Sch. V, line 24, col. 8)		
Lashly & Baer	Therapy contract		467				TOTAL	\$ 24,168	
Williams & McCarthy	W/c Legal		5,358						
Laner Muchin	retainer fee		5,030						
Intracorp	W/c		1,008						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 14,504	TOTAL		\$			

* Attach copy of IMRF notifications

**See instructions.

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.\$10520
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 74,620 Line V10-2
- (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. \$ 104,025
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. \$ 4,320
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.