



Facility Name & ID Number DeKalb County Rehab & Nursing

# 0044321 Report Period Beginning: 12/1/06 Ending: 11/30/07

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 N/A

	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	190	Skilled (SNF)	190	69,350	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	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	1,319	886	6,406	8,611	8	
9	SNF/PED					9	
10	ICF	33,576	23,206	960	57,742	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	34,895	24,092	7,366	66,353	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.68%

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 Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
 YES  NO  Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 \_\_\_\_\_ 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 6,406

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: N/A 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: 12/1/06 Ending: 11/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	558,682	49,636	19,673	627,991		627,991		627,991		1
2	Food Purchase		478,690		478,690		478,690	(29,826)	448,864		2
3	Housekeeping	216,659	48,534	184,951	450,144		450,144		450,144		3
4	Laundry	66,736	6,608		73,344		73,344		73,344		4
5	Heat and Other Utilities			323,041	323,041		323,041		323,041		5
6	Maintenance	98,103	53,447	197,077	348,627		348,627	105,240	453,867		6
7	Other (specify):* <b>Allocated benefits</b>							18,543	18,543		7
8	<b>TOTAL General Services</b>	940,180	636,915	724,742	2,301,837		2,301,837	93,957	2,395,794		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	4,593,002	294,590	297,338	5,184,930		5,184,930		5,184,930		10
10a	Therapy			495,939	495,939		495,939		495,939		10a
11	Activities	131,833	6,157	8,851	146,841		146,841		146,841		11
12	Social Services	149,224	9	2,730	151,963		151,963		151,963		12
13	CNA Training										13
14	Program Transportation			3,302	3,302		3,302		3,302		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,874,059	300,756	808,160	5,982,975		5,982,975		5,982,975		16
	<b>C. General Administration</b>										
17	Administrative	92,697		100,682	193,379		193,379	52,929	246,308		17
18	Directors Fees										18
19	Professional Services			24,425	24,425		24,425	(59)	24,366		19
20	Dues, Fees, Subscriptions & Promotions			22,184	22,184		22,184		22,184		20
21	Clerical & General Office Expenses	201,696	24,973	132,048	358,717		358,717	187,575	546,292		21
22	Employee Benefits & Payroll Taxes			1,968,209	1,968,209		1,968,209	19,492	1,987,701		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,846	15,846		15,846		15,846		24
25	Other Admin. Staff Transportation			2,481	2,481		2,481		2,481		25
26	Insurance-Prop.Liab.Malpractice			33,781	33,781		33,781	17,705	51,486		26
27	Other (specify):* <b>Allocated benefits</b>							55,645	55,645		27
28	<b>TOTAL General Administration</b>	294,393	24,973	2,299,656	2,619,022		2,619,022	333,287	2,952,309		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,108,632	962,644	3,832,558	10,903,834		10,903,834	427,244	11,331,078		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

DeKalb County Rehab &amp; Nursing

#0044321

Report Period Beginning:

12/1/06

Ending:

11/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			612,482	612,482		612,482	23,747	636,229			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			271,139	271,139		271,139	(219,538)	51,601			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			84,437	84,437		84,437		84,437			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			968,058	968,058		968,058	(195,791)	772,267			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			1,706	1,706		1,706		1,706			38
39	Ancillary Service Centers		157,169		157,169		157,169		157,169			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):* <b>Non-allowable Cos</b>			2,581,749	2,581,749		2,581,749	(2,581,749)				43
44	<b>TOTAL Special Cost Centers</b>		157,169	2,687,480	2,844,649		2,844,649	(2,581,749)	262,900			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,108,632	1,119,813	7,488,096	14,716,541		14,716,541	(2,350,296)	12,366,245			45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,016)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	27,112	30		9
10	Interest and Other Investment Income	(219,538)	32		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	(2,531,515)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,050)	43		24
25	Fund Raising, Advertising and Promotional	(9,129)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,097)	21		28
29	Other-Attach Schedule See Pg. 5A	70,307			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,696,926)		\$	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)	346,630		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 346,630		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,350,296)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

DeKalb County Rehab & Nursing

ID# 0044321

Report Period Beginning: 12/1/06

Ending: 11/30/07

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Laboratory Expense	\$ (5,323)	43	1
2	X-Ray Expense	(5,210)	43	2
3	Medicare Cost Report Settlement	(3,555)	43	3
4	Maintenance Revenue	(1,614)	6	4
5	Workers' Compensation Revenue	(2,318)	22	5
6	Miscellaneous Income	(638)	21	6
7	Out-of-Period Legal Expense	(653)	19	7
8	Community Relations	(1,967)	43	8
9	Nonallowable Retainer Legal Expense	(6,000)	19	9
10	Expense Vinyl Wall Covering per client	100,950	6	10
11	Vinyl Wall Covering Depre.	(3,365)	30	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	<b>Total</b>	70,307		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number DeKalb County Rehab &amp; Nursing

# 0044321

Report Period Beginning:

12/1/06

Ending:

11/30/07

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,016)	0	0	0	0	0	0	0	0	0	0	(8,016)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	99,336	0	5,904	0	0	0	0	0	0	0	0	105,240	6
7	Other (specify):*	0	0	18,543	0	0	0	0	0	0	0	0	18,543	7
8	<b>TOTAL General Services</b>	<b>91,320</b>	<b>0</b>	<b>24,447</b>	<b>0</b>	<b>115,767</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	52,929	0	0	0	0	0	0	0	0	52,929	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,653)	0	6,594	0	0	0	0	0	0	0	0	(59)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,735)	0	189,310	0	0	0	0	0	0	0	0	187,575	21
22	Employee Benefits & Payroll Taxes	(2,318)	0	0	0	0	0	0	0	0	0	0	(2,318)	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	17,705	0	0	0	0	0	0	0	0	17,705	26
27	Other (specify):*	0	0	55,645	0	0	0	0	0	0	0	0	55,645	27
28	<b>TOTAL General Administration</b>	<b>(10,706)</b>	<b>0</b>	<b>322,183</b>	<b>0</b>	<b>311,477</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>80,614</b>	<b>0</b>	<b>346,630</b>	<b>0</b>	<b>427,244</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number

DeKalb County Rehab &amp; Nursing

# 0044321

Report Period Beginning:

12/1/06

Ending:

11/30/07

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	23,747	0	0	0	0	0	0	0	0	0	0	23,747	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(219,538)	0	0	0	0	0	0	0	0	0	0	(219,538)	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	<b>TOTAL Ownership</b>	<b>(195,791)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(195,791)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(2,581,749)	0	0	0	0	0	0	0	0	0	0	(2,581,749)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(2,581,749)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,581,749)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(2,696,926)</b>	<b>0</b>	<b>346,630</b>	<b>0</b>	<b>(2,350,296)</b>	<b>45</b>							

**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	N/A		DeKalb County Government		

**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	21 Department Chargeback	\$ 62,000	DeKalb County Government	100.00%	\$ 62,000	\$	1
2	V	22 FICA Taxes	450,854	DeKalb County Government	100.00%	450,854		2
3	V	22 IMRF	424,953	DeKalb County Government	100.00%	424,953		3
4	V	22 Health Insurance	802,458	DeKalb County Government	100.00%	802,458		4
5	V	22 Workers Comp	25,658	DeKalb County Government	100.00%	25,658		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,765,923			\$ 1,765,923	\$ *	14

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

VII. RELATED PARTIES (continued)

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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Maintenance	\$	DeKalb County, Illinois	100.00%	\$ 5,904	\$	5,904	15
16	V	7 Employee Benefits-Plant		DeKalb County, Illinois	100.00%	18,543		18,543	16
17	V	17 County Board Costs		DeKalb County, Illinois	100.00%	52,929		52,929	17
18	V	19 State's Attorney		DeKalb County, Illinois	100.00%	6,594		6,594	18
19	V	21 Departmental and non-departmental costs		DeKalb County, Illinois	100.00%	189,310		189,310	19
20	V								20
21	V	26 Risk Management		DeKalb County, Illinois	100.00%	17,705		17,705	21
22	V	27 Employee Benefits-G&A		DeKalb County, Illinois	100.00%	55,645		55,645	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 346,630	\$ *	346,630	39

\* 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: 12/1/06 Ending: 11/30/07

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	See attached Schedule 7A.								\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number DeKalb County Rehab & Nursing

# 0044321

Report Period Beginning:

12/1/06

Ending: 11/30/07

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 DeKalb County, Illinois  
 Street Address 110 E. Sycamore St.  
 City / State / Zip Code Sycamore, IL 60178  
 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	6	Maintenance	*	*	\$ 1,448,081	\$		\$ 5,904	1	
2	7	Employee Benefits-Plant	*	*	50,290			18,543	2	
3	17	County Board Costs	*	*	452,825			52,929	3	
4	19	State's Attorney	*	*	1,901,526			6,594	4	
5	21	Departmental and non-departmental costs	*	*	3,265,144			189,310	5	
6									6	
7	26	Risk Management	*	*	545,726			17,705	7	
8	27	Employee Benefits-G&A	*	*	150,915			55,645	8	
9	30	Depreciation	*	*	447,846			0	9	
10									10	
11		* See attached Maximus Indirect Allocation Plan - 2007 for method of allocation.								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				\$ 8,262,353	\$		\$ 346,630	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

DeKalb County Rehab & Nursing

# 0044321

Report Period Beginning:

12/1/06

Ending:

11/30/07

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Bonds	X		Facility Construction	Varies	2005	\$ 7,155,000	\$ 5,739,138	2016	0.0520	\$ 271,139	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 7,155,000	\$ 5,739,138			\$ 271,139	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13									Interest Income Offset		(219,538)	13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (219,538)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 7,155,000	\$ 5,739,138			\$ 51,601	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 Catherine Anderson

TELEPHONE 815-758-2477 FAX #: 815-758-3176

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. <u>County facility - exempt from real estate</u>	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number DeKalb County Rehab & Nursing

# 0044321

Report Period Beginning:

12/1/06

Ending:

11/30/07

**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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1		<u>243,065</u>	<u>1998</u>	<u>\$ 83,098</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>243,065</u>		<u>\$ 83,098</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	190	2000	2000	\$ 10,887,894	\$ 408,404	25	\$ 435,516	\$ 27,112	\$ 3,375,247	4
5		2000	2000	117,663	4,706	25	4,706		36,476	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Construction Cap. Rpt cost - new building 3/9/00		1999	12,293	800	10 to 20	800		6,813	9
10	Construction Cap. Rpt cost - new building 3/9/00		2000	10,553	654	15 to 25	654		5,077	10
11	Cap. Rpt. Costs - new building since 3/9/00		2000	37,957	2,157	10 to 25	2,157		15,786	11
12	Maint. Building see fac. Letter and OHF rpt 6/18/01		2000	109,759	5,488	20	5,488		42,532	12
13	Electric,Acoustical duct repair,seal coat dry wall		2001	21,598	869	5 to 24	869		8,605	13
14	Half gate,workstation,swing door,gazebo, & concrete		2001	63,940	4,219	15 to 20	4,219		27,167	14
15	Duct repair,dumpster,slab,stainless steel-kitchen,		2002	10,421	774	5 to 25	774		4,935	15
16	Employee entrance & courtyard landscaping		2003	11,355	1,135	10	1,135		4,908	16
17	Locks on doors, stainless steel walls dietary,lot lights		2004	30,177	2,804	6 to 15	2,804		10,331	17
18	Maint. Mezzanine, replace fire system, fire lane, compressor		2005	24,617	2,775	5 to 20	2,775		6,676	18
19	Architect,construction,painting,programming, dementia unit		2005	339,823	29,700	20	29,700		59,400	19
20	Mirror,painting,replace concrete CVS,replace 29 sprinklers		2006	9,978	969	5 to 18	969		1,384	20
21	Replace 2 doors, add magnets, install magnets & smoke detectors		2006	13,813	1,002	5	1,002		1,181	21
22	Painting in dining rooms		2007	7,840	1,568	5	1,568		1,568	22
23	Replace 600aMP Switch		2007	4,847	280	13	280		280	23
24	New Phone System		2007	22,000	185	10	185		185	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

SEE ACCOUNTANTS' COMPILATION REPORT

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)	\$ 11,736,528	\$ 468,489		\$ 495,601	\$ 27,112	\$ 3,608,551	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 382,229	\$ 139,074	\$ 139,074	\$	5 to 15	\$ 750,886	71
72	Current Year Purchases	35,988	1,554	1,554		5 to 15	1,554	72
73	Fully Depreciated Assets	385,203				5 to 15	385,203	73
74								74
75	TOTALS	\$ 803,420	\$ 140,628	\$ 140,628	\$		\$ 1,137,643	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	Ford Bus	1989	\$ 38,695	\$	\$	\$	8	\$ 38,695	76
77	Maintenance	1995 GMC 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)	\$ 12,684,124	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 609,117	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 636,229	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 27,112	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,807,272	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 84,437 Description: Medical-\$73,314; Postage Mach.-\$378; Copier-\$8,843; Construction-\$1,593; Plumbing-\$130, Electrical-\$179

(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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

**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	\$	5,849	\$ 350,919	\$	5,849	\$ 350,919	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		327	19,595		327	19,595	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,090	125,425		2,090	125,425	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				157,169		157,169	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	<b>TOTAL</b>			\$	8,266	\$ 495,939	\$ 157,169	8,266	\$ 653,108	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number DeKalb County Rehab & Nursing

# 0044321

Report Period Beginning: 12/1/06

Ending:

11/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/07

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 366,129	\$ 366,129	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,721 )	2,834,343	2,834,343	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	2,954,602	2,954,602	5
6	Prepaid Insurance	66,035	66,035	6
7	Other Prepaid Expenses	33,828	33,828	7
8	Accounts Receivable (owners or related parties)	1,697,531	1,697,531	8
9	Other(specify): <u>Development Costs</u>	2,890	2,890	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 7,955,358</b>	<b>\$ 7,955,358</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,098	83,098	13
14	Buildings, at Historical Cost	11,115,316	11,005,557	14
15	Leasehold Improvements, at Historical Cost	613,371	730,971	15
16	Equipment, at Historical Cost	1,592,209	864,498	16
17	Accumulated Depreciation (book methods)	(4,991,847)	(4,807,272)	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 (spec <u>Courtyard Program</u> )	3,332		22
23	Other(specify): <u>Reserve for IGT</u>	354,835		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 8,770,314</b>	<b>\$ 7,876,852</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 16,725,672</b>	<b>\$ 15,832,210</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 650,802	\$ 650,802	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	500,730	500,730	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	126,277	126,277	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	83,190	83,190	34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Reserve for W/C Settlements</u>	241,270	241,270	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 1,602,269</b>	<b>\$ 1,602,269</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,739,138	5,739,138	41
42	Deferred Compensation	373,515	373,515	42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 6,112,653</b>	<b>\$ 6,112,653</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 7,714,922</b>	<b>\$ 7,714,922</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 9,010,750</b>	<b>\$ 8,117,288</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 16,725,672</b>	<b>\$ 15,832,210</b>	<b>48</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>8,475,711</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>8,475,711</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>535,039</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>535,039</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>9,010,750</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 14,515,768	1
2	Discounts and Allowances for all Levels	(1,769,582)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,746,186	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,180,683	6
7	Oxygen	153,344	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,334,027	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	247,665	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,016	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	267,166	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,516	19
20	Radiology and X-Ray	4,139	20
21	Other Medical Services	389,045	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 922,547	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	24,712	24
25	Interest and Other Investment Income***	219,538	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 244,250	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Maintenance & W/C Salary Reimbursement	3,932	28
28a	Miscellaneous	638	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,570	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,251,580	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,301,837	31
32	Health Care	5,982,975	32
33	General Administration	2,619,022	33
<b>B. Capital Expense</b>			
34	Ownership	968,058	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,740,624	35
36	Provider Participation Fee	104,025	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,716,541	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	535,039	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 535,039	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return?  N/A  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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number DeKalb County Rehab & Nursing

# 0044321

Report Period Beginning:

12/1/06

Ending:

11/30/07

**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	3,647	4,185	\$ 139,753	\$ 33.39	1
2	Assistant Director of Nursing	5,320	6,337	194,098	30.63	2
3	Registered Nurses	48,895	54,530	1,585,094	29.07	3
4	Licensed Practical Nurses	12,479	13,322	293,240	22.01	4
5	CNAs & Orderlies	151,931	166,395	2,197,623	13.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,060	10,821	183,194	16.93	8
9	Activity Director	1,716	2,093	35,207	16.82	9
10	Activity Assistants	9,230	10,312	96,626	9.37	10
11	Social Service Workers	7,390	8,369	149,224	17.83	11
12	Dietician	1,906	2,267	34,972	15.43	12
13	Food Service Supervisor	1,809	2,093	45,802	21.88	13
14	Head Cook	1,985	2,266	29,083	12.83	14
15	Cook Helpers/Assistants	44,632	48,753	448,825	9.21	15
16	Dishwashers					16
17	Maintenance Workers	4,989	5,635	98,103	17.41	17
18	Housekeepers	21,109	23,114	216,659	9.37	18
19	Laundry	7,142	7,737	66,736	8.63	19
20	Administrator	2,160	2,160	92,697	42.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,012	14,438	201,696	13.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	348,412	384,827	\$ 6,108,632 *	\$ 15.87	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	444	\$ 19,673	1(3)	35
36	Medical Director				36
37	Medical Records Consultant	287	5,735	10(3)	37
38	Nurse Consultant	1,573	135,553	10(3)	38
39	Pharmacist Consultant	Monthly	5,244	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	22	1,518	11(3)	44
45	Social Service Consultant	44	2,537	12(3)	45
46	Other(specify) <u>Dental</u>	Monthly	900	10(3)	46
47	<u>Utilization Review</u>	Monthly	9,042	10(3)	47
48	<u>Dementia Consultant</u>	22	1,518	10(3)	48
49	TOTAL (lines 35 - 48)	2,392	\$ 181,720		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	41	\$ 2,784	10(3)	50
51	Licensed Practical Nurses	2,425	109,501	10(3)	51
52	Certified Nurse Assistants/Aides	1,149	24,421	10(3)	52
53	TOTAL (lines 50 - 52)	3,615	\$ 136,706		53

SEE ACCOUNTANTS' COMPILATION REPORT



**DeKalb County Rehab & Nursing Center**

**Provider #: 0044321**

**12/1/06 - 11/30/07**

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Total (agree to Schedule V, line 19, column 3)		24,425
Nonallowable Legal Expenses - Out-of-Period		(653)
Nonallowable Legal Expenses - Retainer		(6,000)
State's Attorney Indirect Cost Allocation from DeKalb County		<u>6,594</u>
Total (agree to Schedule V, line 19, column 8)		<u><u>24,366</u></u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

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

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4		N/A																		
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number DeKalb County Rehab & Nursing# 0044321

Report Period Beginning:

12/1/06

Ending:

11/30/07**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network - \$12,254
- (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? N/A
- (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? 5-15 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 64,842 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (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. \$ 21,810 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,016
- (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? 57  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
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. Audit not yet complete
- (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

**SEE ACCOUNTANTS' COMPILATION REPORT**