



Facility Name & ID Number DeKalb County Rehab & Nursing

# 0044321 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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	69,540	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	69,540	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	1,355	314	6,675	8,344	8
9	SNF/PED					9
10	ICF	32,923	24,341		57,264	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,278	24,655	6,675	65,608	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.35%

#REF!

D. How many bed-hold days during this year were paid by the Department? None (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 6,675

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  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

## STATE OF ILLINOIS

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Facility Name &amp; ID Number DeKalb County Rehab &amp; Nursing # 0044321 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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	575,682	51,230	21,228	648,140		648,140		648,140		1
2	Food Purchase		532,636		532,636		532,636	(9,553)	523,083		2
3	Housekeeping	228,964	58,546	204,051	491,561		491,561		491,561		3
4	Laundry	66,897	5,118		72,015		72,015		72,015		4
5	Heat and Other Utilities			370,142	370,142		370,142		370,142		5
6	Maintenance	108,291	43,509	195,676	347,476		347,476	6,588	354,064		6
7	Other (specify):* Allocated Benefits							20,800	20,800		7
8	<b>TOTAL General Services</b>	979,834	691,039	791,097	2,461,970		2,461,970	17,835	2,479,805		8
<b>B. Health Care and Programs</b>											
9	Medical Director										9
10	Nursing and Medical Records	4,862,851	300,931	209,689	5,373,471		5,373,471		5,373,471		10
10a	Therapy			556,215	556,215		556,215		556,215		10a
11	Activities	135,318	3,073	2,378	140,769		140,769		140,769		11
12	Social Services	160,750		2,967	163,717		163,717		163,717		12
13	CNA Training										13
14	Program Transportation			2,568	2,568		2,568		2,568		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	5,158,919	304,004	773,817	6,236,740		6,236,740		6,236,740		16
<b>C. General Administration</b>											
17	Administrative	92,839		149,438	242,277		242,277	59,060	301,337		17
18	Directors Fees										18
19	Professional Services			56,741	56,741		56,741	5,231	61,972		19
20	Dues, Fees, Subscriptions & Promotion			56,304	56,304		56,304	(5,496)	50,808		20
21	Clerical & General Office Expense	229,854	46,663	107,583	384,100		384,100	211,238	595,338		21
22	Employee Benefits & Payroll Tax			1,804,467	1,804,467		1,804,467		1,804,467		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,782	8,782		8,782		8,782		24
25	Other Admin. Staff Transportation			1,746	1,746		1,746		1,746		25
26	Insurance-Prop.Liab.Malpractice			36,021	36,021		36,021	19,755	55,776		26
27	Other (specify):* Allocated Benefits							61,981	61,981		27
28	<b>TOTAL General Administration</b>	322,693	46,663	2,221,082	2,590,438		2,590,438	351,769	2,942,207		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,461,446	1,041,706	3,785,996	11,289,148		11,289,148	369,604	11,658,752		29

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

#REF!

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

V. COST CENTER EXPENSES (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			627,251	627,251	627,251	77	627,328			30
31	Amortization of Pre-Op. & Org										31
32	Interest			244,241	244,241	244,241	(165,536)	78,705			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicle:			86,279	86,279	86,279		86,279			35
36	Other (specify): <sup>3</sup>										36
37	<b>TOTAL Ownership</b>			957,771	957,771	957,771	(165,459)	792,312			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportatior			378	378	378		378			38
39	Ancillary Service Center:		164,052		164,052	164,052		164,052			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shop:										41
42	Provider Participation Fee			2,496,809	2,496,809	2,496,809		2,496,809			42
43	Other (specify): <sup>3</sup> <b>Non-allowable cost</b>			56,862	56,862	56,862	(56,862)				43
44	<b>TOTAL Special Cost Centers</b>		164,052	2,554,049	2,718,101	2,718,101	(56,862)	2,661,239			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,461,446	1,205,758	7,297,816	14,965,020	14,965,020	147,283	15,112,303			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.

#REF!

Facility Name & ID Number DeKalb County Rehab & Nursing

# 0044321

Report Period Beginning: 01/01/08

Ending:

12/31/08

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 Program				3
4	Non-Patient Meals	(9,553)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	77	30		9
10	Interest and Other Investment Income	(165,536)	32		10
11	Discounts, Allowances, Rebates & Refund				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 Transaction				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 Retainer	(2,126)	19		22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(46,034)	43		24
25	Fund Raising, Advertising and Promotions	(5,496)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(10,828)	var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (239,496)		\$	30

BHF USE ONLY					
48		49	50	51	52

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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)	386,779		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 386,779		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 147,283		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 Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

DeKalb County Rehab & Nursing

ID# 0044321

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing & Public Relations	\$ (1,848)	43	1
2	Medicare lab fees	(5,634)	43	2
3	Medicare reaiology fees	(8,300)	43	3
4	Medicare Cost Report settlement	6,081	43	4
5	Community Relations	(1,127)	43	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	<b>Total</b>	(10,828)		49

#REF!

## STATE OF ILLINOIS

Summary A

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

# 0044321

Report Period Beginning:

01/01/08

Ending:

12/31/08

## 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	(9,553)	0	0	0	0	0	0	0	0	0	0	(9,553)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	6,588	0	0	0	0	0	0	0	0	6,588	6
7	Other (specify):*	0	0	20,800	0	0	0	0	0	0	0	0	20,800	7
8	<b>TOTAL General Services</b>	(9,553)	0	27,388	0	0	0	0	0	0	0	0	17,835	8
	<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>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	59,060	0	0	0	0	0	0	0	0	59,060	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,126)	0	7,357	0	0	0	0	0	0	0	0	5,231	19
20	Fees, Subscriptions & Promotions	(5,496)	0	0	0	0	0	0	0	0	0	0	(5,496)	20
21	Clerical & General Office Expenses	0	0	211,238	0	0	0	0	0	0	0	0	211,238	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	19,755	0	0	0	0	0	0	0	0	19,755	26
27	Other (specify):*	0	0	61,981	0	0	0	0	0	0	0	0	61,981	27
28	<b>TOTAL General Administration</b>	(7,622)	0	359,391	0	0	0	0	0	0	0	0	351,769	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(17,175)	0	386,779	0	0	0	0	0	0	0	0	369,604	29



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, Illinois	100	N/A		DeKalb County, IL	DeKalb	County Govt.

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	\$ 82,000	DeKalb County, Illinois	100.00%	\$ 82,000	\$	1
2	V	22 FICA Taxes	476,476	DeKalb County, Illinois	100.00%	476,476		2
3	V	22 IMRF	478,456	DeKalb County, Illinois	100.00%	478,456		3
4	V	22 Health Insurance	848,206	DeKalb County, Illinois	100.00%	848,206		4
5	V	22 Workers Comp	(94,822)	DeKalb County, Illinois	100.00%	(94,822)		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		\$ 1,790,316			\$ 1,790,316	\$ *	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: 01/01/08

Ending: 12/31/08

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%	\$ 6,588	\$ 6,588
16	V	7 Employee Benefits-Plant		DeKalb County, Illinois	100.00%	20,800	20,800
17	V	17 County Board Costs		DeKalb County, Illinois	100.00%	59,060	59,060
18	V	19 State's Attorney		DeKalb County, Illinois	100.00%	7,357	7,357
19	V	21 Departmental and non-departmental costs		DeKalb County, Illinois	100.00%	211,238	211,238
20	V						
21	V	26 Risk Management		DeKalb County, Illinois	100.00%	19,755	19,755
22	V	27 Employee Benefits-G&A		DeKalb County, Illinois	100.00%	61,981	61,981
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 386,779	\$ * 386,779

\* Total must agree with the amount recorded on line 34 of Schedule V1

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Facility Name & ID Number      DeKalb County Rehab & Nursing      #      0044321      Report Period Beginning:      01/01/08      Ending:      12/31/08

## 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	<b>OPERATING BOARD</b>								\$		1	
2	Veronica Casella	Chairperson	Administrative	0.00	NONE	1	2.00	N/A	0	N/A	2	
3	Dick Ubl	Member	Administrative	0.00	NONE	1	2.00	N/A	0	N/A	3	
4	Tuth Ann tobias	Member	Administrative	0.00	NONE	1	2.00	N/A	0	N/A	4	
5	George Daugherty	Member	Administrative	0.00	NONE	1	2.00	N/A	0	N/A	5	
6	Nate Kloster	Member	Administrative	0.00	NONE	1	2.00	N/A	0	N/A	6	
7	Eileen Dubin	Member	Administrative	0.00	NONE	1	2.00	N/A	0	N/A	7	
8	Ron Klein	Member	Administrative	1.00	NONE	1	2.00	N/A	0	N/A	8	
9											9	
10											10	
11	No members of the board provide services or received compensation from the nursing home											11
12											12	
13								<b>TOTAL</b>	\$		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.

#REF!

Facility Name & ID Number DeKalb County Rehab & Nursing # 0044321 Report Period Beginning: 01/01/08 Ending: 12/31/08

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 610178  
 Phone Number (815) 895-7189  
 Fax Number (815) 895-7187

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	*	*	\$ 6,588	\$		\$ 6,588	1
2	7	Employee Benefits-Plant	*	*	20,800			20,800	2
3	17	County Board Costs	*	*	59,060			59,060	3
4	19	State's Attorney	*	*	7,357			7,357	4
5	21	Departmental and	*	*	211,238			211,238	5
6		non-departmental costs							6
7	26	Risk Management	*	*	19,755			19,755	7
8	27	Employee Benefits-G&A	*	*	61,981			61,981	8
9	30	Depreciation	*	*					9
10									10
11		* See Schedule 8A 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				\$ 386,779	\$		\$ 386,779	25

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DeKalb County Rehab & Nursing  
 Provider #: 0044321  
 01/010/08 - 12/31/08

**Schedule 8A**

**Allocation of Indirect Costs from DeKalb County**

<u>Central Service Dept</u>	<sup>②</sup> <u>Amount</u>	<u>Cost Center</u>	<u>Schedule V Reference</u>
Non-departmental	32,683	Clerical	21
FICA & IMRF	82,781 <sup>①</sup>	EE Benefits	④ ●
Risk Management	19,755	Insurance	26
Facilities Management	6,588	Plant Maint.	6
Finance	149,825	Clerical	21
Information Management	19,395	Clerical	21
Treasurer	9,335	Clerical	21
State's Attorney	7,357	Prof. Fees	19
County Board	59,060	Admin	17
	<u>386,779</u>		

<sup>③</sup> <u>Allocation of FICA &amp; IMRF</u>	<u>Wages from WTB</u>	<u>Wages</u>	<u>Allocation</u>	<u>Sch V Reference</u>
<i>IMRF &amp; FICA are allocated between General Services and General Administration since any wage related allocation from the county would come from those areas.</i>	Plant	108,291	20,800	④ ●
	G&A	322,693	61,981	27
		<u>430,984</u>	<u>82,781</u> <sup>①</sup>	

- ② Amounts - 103% of 2007 Allocation from Maximus Report
- ③ IMRF & FICA allocated between cost center on L7 & L27 as these are the only cost center affected by the allocation. No nursing or other health care costs have been allocated.

NOTE: This workpaper allocates indirect county cost to the nursing facility. We have taken the Maximus report issued in 2008 and updated the allocated costs from 2007 to 2008 using an annual inflation factor of 3%.

Facility Name & ID Number DeKalb County Rehab & Nursing # 0044321 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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	
						Original	Balance					
	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									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Bonds	X		Facility Construction	Varies	2005	\$ 7,155,000	\$ 5,225,388	2016	0.0520	\$ 244,241	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 7,155,000	\$ 5,225,388			\$ 244,241	9
	<b>B. Non-Facility Related*</b>											
10									Interest income offset		(165,536)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (165,536)	14
15	TOTALS (line 9+line14)						\$ 7,155,000	\$ 5,225,388			\$ 78,705	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.) #REF!

\*\* 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

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and <b>must accompany the cost report</b></p>			
1. Real Estate Tax accrual used on 2007 report.		\$	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.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2008 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	8	
	2004	9	
	2005	10	
	2006	11	
	2007	N/A	12
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
<b>County facility - exempt from real estate tax</b>	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**

#REF!

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 Doreen Akers

TELEPHONE (815) 758-2477 FAX #: (815) 217-0451

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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. <u>County facility - exempt from real estate</u>	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
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 N/A 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

#REF!

Facility Name & ID Number DeKalb County Rehab & Nursing

# 0044321 Report Period Beginning:

01/01/08 Ending:

12/31/08

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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>243,065</u>	<u>1998</u>	<u>\$ 83,098</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<u>243,065</u>		<u>\$ 83,098</u>	<u>3</u>

#REF!



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)	\$ 11,811,585	\$ 475,594		\$ 502,706	\$ 27,112	\$ 4,153,001	70

#REF!

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

Facility Name & ID Number: DeKalb County Rehab & Nursing # 0044321 Report Period Beginning: 01/01/08 Ending: 12/31/08  
 XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ 1,431,121	\$ 150,103	\$ 123,068	\$ (27,035)		\$ 550,120	71
72	Current Year Purchases	277,891	1,554	1,554			1,554	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,709,012	\$ 151,657	\$ 124,622	\$ (27,035)		\$ 551,674	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				\$	\$	\$	\$		\$	76
77	Maintenance	1995 GMC Truck	1996	22,383				5	22,383	77
78										78
79										79
80	TOTALS			\$ 22,383	\$	\$	\$		\$ 22,383	80

E. Summary of Care-Related Asset

	1	2	
	Reference	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)	\$ 13,626,078	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 627,251	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 627,328	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 77	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,727,058	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			N/A		87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	Description	Cost	
92		\$	92
93		N/A	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 1

#REF!

**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				<u>N/A</u>			4
5								5
6								6
7	<b>TOTAL</b>				\$			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. /2009 \$ \_\_\_\_\_  
 13. /2010 \$ \_\_\_\_\_  
 14. /2011 \$ \_\_\_\_\_

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: \$ 86,279 Description: Nursing Equip-72,721; Postage Meter-378; Copier-8,825; Maintenance Equip-4,355  
 (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			<u>N/A</u>		18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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>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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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 Wage (c)				
6	Transportation				
7	Contractual Payment:				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (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

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

###

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,822	\$	147,888				1,822	\$	147,888	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		472		25,790				472		25,790	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10A(3)	hrs		4,538		382,537				4,538		382,537	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							164,052			164,052	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Other (specify):													12
13	Other (specify):													13
14	TOTAL			\$	6,832	\$	556,215	\$	164,052		6,832	\$	720,267	14

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

#REF!

Facility Name & ID Number DeKalb County Rehab & Nursing

# 0044321

Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ 515,511	\$ 515,511	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 155,639 )	3,077,167	3,077,167	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	2,990,281	2,990,281	5
6	Prepaid Insurance	68,330	68,330	6
7	Other Prepaid Expenses	57,592	57,592	7
8	Accounts Receivable (owners or related parties)	1,480,432	1,480,432	8
9	Other(specify): Sr. Living Facility-Dev.	3,992	3,992	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 8,193,305</b>	<b>\$ 8,193,305</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	688,429	806,028	15
16	Equipment, at Historical Cost	1,732,676	1,731,395	16
17	Accumulated Depreciation (book methods)	(5,596,882)	(4,727,058)	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 (sp Const in progress)	3,332	3,332	22
23	Other(specify): Reserve for IGT	100,348	100,348	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 8,126,317</b>	<b>\$ 9,002,700</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 16,319,622</b>	<b>\$ 17,196,005</b>	<b>25</b>

#REF!

\*(See instructions.)

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 795,813	\$ 795,813	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	445,937	445,937	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	210,742	210,742	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	239,545	239,545	34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Interest Payable & Work Comp	14,732	14,732	36
37	Reserve			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 1,706,769</b>	<b>\$ 1,706,769</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,225,388	5,225,388	41
42	Deferred Compensation	381,710	381,710	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>\$ 5,607,098</b>	<b>\$ 5,607,098</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 7,313,867</b>	<b>\$ 7,313,867</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 9,005,755</b>	<b>\$ 9,882,138</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 16,319,622</b>	<b>\$ 17,196,005</b>	<b>48</b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,010,750	1
2	Restatements (describe):		2
3	Prior period adjustment	(292,424)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,718,326	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	287,429	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 287,429	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,005,755	24 *

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

#REF!

**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 expenses.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 14,671,257	1
2	Discounts and Allowances for all Level	(1,984,141)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 12,687,116</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,260,839	6
7	Oxygen	140,906	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,401,745</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Educator		9
10	Other Government Grants	208,042	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,553	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	237,730	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	7,238	19
20	Radiology and X-Ray	9,971	20
21	Other Medical Services	463,973	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 936,507</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	20,387	24
25	Interest and Other Investment Income**	165,536	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 185,923</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Maintenance 1,817; Work comp salary reimb 2,353	4,170	28
28a	Misc. 8,988; Prior Period Settlement 28,000	36,988	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 41,158</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 15,252,449</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,461,970	31
32	Health Care	6,236,740	32
33	General Administrator	2,590,438	33
<b>B. Capital Expense</b>			
34	Ownership	957,771	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	221,292	35
36	Provider Participation Fee	2,496,809	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 14,965,020</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>287,429</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 287,429</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
 County facility

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. #REF!

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

Facility Name & ID Number DeKalb County Rehab & Nursing

# 0044321

Report Period Beginning: 01/01/08

Ending:

12/31/08

VIII. 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	1,790	2,243	\$ 86,062	\$ 38.37	1
2	Assistant Director of Nursing	1,235	1,325	43,131	32.55	2
3	Registered Nurses	35,734	41,210	1,268,377	30.78	3
4	Licensed Practical Nurses	18,917	20,431	499,852	24.47	4
5	CNAs & Orderlies	150,955	164,484	2,256,501	13.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,068	8,167	123,060	15.07	8
9	Activity Director	1,763	2,185	39,059	17.88	9
10	Activity Assistants	8,589	9,804	96,259	9.82	10
11	Social Service Worker	7,316	8,400	160,750	19.14	11
12	Dietician					12
13	Food Service Supervisor	3,798	4,721	93,075	19.72	13
14	Head Cook	1,921	2,179	29,581	13.58	14
15	Cook Helpers/Assistants	6,698	7,553	90,261	11.95	15
16	Dishwashers	35,565	38,879	362,765	9.33	16
17	Maintenance Worker	4,883	5,507	108,291	19.66	17
18	Housekeepers	20,798	22,552	228,964	10.15	18
19	Laundry	6,425	7,144	66,897	9.36	19
20	Administrator	2,080	2,080	92,839	44.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,827	14,803	229,854	15.53	24
25	Vocational Instructor					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: See Sch 20A	14,647	16,354	519,077	31.74	32
33	Other(specify) See Sch 20A	1,750	2,015	66,791	33.15	33
34	TOTAL (lines 1 - 33)	344,759	382,036	\$ 6,461,446 *	\$ 16.91	34

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	457	\$ 21,228	1(3)	35
36	Medical Director	33	8,475	9(3)	36
37	Medical Records Consultant	311	6,220	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,801	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				44
45	Social Service Consultant	43	2,365	12(3)	45
46	Other(specify) Social Service Cons	26	1,797	12(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	870	\$ 45,886		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	617	\$ 26,986	10(3)	50
51	Licensed Practical Nurses	2,213	86,589	10(3)	51
52	Certified Nurse Assistants/Aides	3,085	69,900	10(3)	52
53	TOTAL (lines 50 - 52)	5,915	\$ 183,475		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

###

DeKalb County Rehab & Nursing  
Provider #: 0044321  
01/010/08 - 12/31/08

**Schedule 20A**

**XVIII. A. STAFFING AND SALARY COSTS - Line 32 Other Health**

<u>Description</u>	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Salary</u>	<u>Ave. Hrly. Wage</u>
Medicare Case Workers	4,188	4,451	130,250	29.26
Inservice Instructors	994	1,111	40,297	36.27
Care Plan Coordinator	1,855	2,106	69,628	33.06
Hours Supervisor	5,740	6,540	240,223	36.73
Scheduling Coordinator	1,870	2,146	38,679	18.02
	<u>14,647</u>	<u>16,354</u>	<u>519,077</u>	<u>31.74</u>

**XVIII. A. STAFFING AND SALARY COSTS - Line 33 Other**

<u>Description</u>	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Salary</u>	<u>Ave. Hrly. Wage</u>
Corporate Compliance Officer	<u>1,750</u>	<u>2,015</u>	<u>66,791</u>	<u>33.15</u>



DeKalb County Rehab & Nursing

Provider #: 0044321

01/01/08 - 12/31/08

**Schedule 21A**

**XIX. SUPPORT SERVICES - Sec> C Professional Services**

Per Schedule V, Line 19, Column 3            56,741

Add: Indirect County Allocation            7,357

Less: Non-allowable legal retainers        (2,126)

To Schedule V, Line 19, Column 8        61,972

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

#REF!

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? If YES, give association name and amount Life Services Network - 9,054 Yes
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report N/A
- (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? What was the average life used for new equipment added during this period? Yes 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 76,445 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? If YES, give effective date of lease No 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 N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. 2,496,809 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 for an individual employee? No If YES, attach an explanation of the allocation  
#REF!
- (13) Have costs for all supplies and services which are of the type that can be billed 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 example, 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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,553
- (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 program during this reporting period. N/A  
 c. What percent of all travel expense relates to transportation of nurses and patient?         
 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 \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
 Firm Name: Sikich, Gardner & Co. 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? N/A  
 Attach invoices and a summary of services for all architect and appraisal fees



	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	515,511	515,511
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	3,077,167	3,077,167
4. Supply Inventory	0	0
5. Short-Term Investments	2,990,281	2,990,281
6. Prepaid Insurance	68,330	68,330
7. Other Prepaid Expenses	57,592	57,592
8. Accounts Receivable-Owner/Related Party	1,480,432	1,480,432
9. Other (specify):	3,992	3,992
10. Total current assets	8,193,305	8,193,305
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	83,098	83,098
14. Buildings, at Historical Cost	11,115,316	11,005,557
15. Leasehold Improvements, Historical Cost	688,429	806,028
16. Equipment, at Historical Cost	1,732,676	1,731,395
17. Accumulated Depreciation (book methods)	-5,596,882	-4,727,058
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	3,332	3,332
23. other (specify):	100,348	100,348
24. Total Long-Term Assets	8,126,317	9,002,700
25. Total Assets	16,319,622	17,196,005
CURRENT LIABILITIES		
26. Accounts Payable	795,813	795,813
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	445,937	445,937
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	210,742	210,742
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	239,545	239,545
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	14,732	14,732
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,706,769	1,706,769
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	5,225,388	5,225,388
42. Deferred Compensation	381,710	381,710
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	5,607,098	5,607,098
46. Total Liabilities	7,313,867	7,313,867
47. Total Equity	9,005,755	9,882,138
48. Total Liabilities and Equity	16,319,622	17,196,005

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	14,671,257
2. Discounts and Allowances for all Levels	-1,984,141
Subtotal - Inpatient Care	12,687,116
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,260,839
7. Oxygen	140,906
Subtotal - Ancillary Revenue	1,401,745
9. Payments for Education	0
10. Other Governmental Grants	208,042
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	9,553
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	237,730
18. Sale of Supplies to Non-Patients	0
19. Laboratory	7,238
20. Radiology and X-Ray	9,971
21. Other Medical Services	463,973
22. Laundry	0
Subtotal - Other Operating Revenue	936,507
24. Contributions	20,387
25. Interest and Other Investments Income	165,536
Subtotal - Non-Operating Revenue	185,923
27. Other Revenue (specify):	4,170
28. Other Revenue (specify):	36,988
Subtotal - Other Revenue	41,158
30. Total Revenue	15,252,449
31. General Services	2,461,970
32. Health Care	6,236,740
33. General Administration	2,590,438
34. Ownership	957,771
35. Special Cost Centers	2,613,791
35. Provider Participation Fee	104,310
37. Other	0
40. Total Expenses	14,965,020
41. Income Before Income Taxes	287,429
42. Income Taxes	0
43. Net Income or Loss for the Year	287,429