

Facility Name & ID Number DeKalb County Rehab & Nursing

0044321 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,231	126	6,598	7,955	8
9	SNF/PED					9
10	ICF	37,432	18,663		56,095	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,663	18,789	6,598	64,050	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.36%

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 6,598

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL 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:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	578,310	47,182	21,312	646,804		646,804		646,804		1
2	Food Purchase		560,139		560,139		560,139	(9,550)	550,589		2
3	Housekeeping	227,312	57,607	190,366	475,285		475,285		475,285		3
4	Laundry	68,879	5,509		74,388		74,388		74,388		4
5	Heat and Other Utilities			306,001	306,001		306,001		306,001		5
6	Maintenance	103,989	42,537	122,910	269,436		269,436	6,720	276,156		6
7	Other (specify):*							21,216	21,216		7
8	TOTAL General Services	978,490	712,974	640,589	2,332,053		2,332,053	18,386	2,350,439		8
	B. Health Care and Programs										
9	Medical Director							122,228	122,228		9
10	Nursing and Medical Records	5,099,933	327,530	383,050	5,810,513		5,810,513	(122,228)	5,688,285		10
10a	Therapy			597,428	597,428		597,428		597,428		10a
11	Activities	129,410	1,570	3,113	134,093		134,093		134,093		11
12	Social Services	159,488		2,567	162,055		162,055		162,055		12
13	CNA Training										13
14	Program Transportation			3,024	3,024		3,024		3,024		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,388,831	329,100	989,182	6,707,113		6,707,113		6,707,113		16
	C. General Administration										
17	Administrative	82,911		155,257	238,168		238,168	60,241	298,409		17
18	Directors Fees										18
19	Professional Services			58,041	58,041		58,041	1,504	59,545		19
20	Dues, Fees, Subscriptions & Promotions			45,474	45,474		45,474		45,474		20
21	Clerical & General Office Expenses	181,479	38,118	98,401	317,998		317,998	215,463	533,461		21
22	Employee Benefits & Payroll Taxes			2,207,475	2,207,475		2,207,475		2,207,475		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,551	9,551		9,551		9,551		24
25	Other Admin. Staff Transportation			1,720	1,720		1,720		1,720		25
26	Insurance-Prop.Liab.Malpractice			30,871	30,871		30,871	20,151	51,022		26
27	Other (specify):*							63,220	63,220		27
28	TOTAL General Administration	264,390	38,118	2,606,790	2,909,298		2,909,298	360,579	3,269,877		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,631,711	1,080,192	4,236,561	11,948,464		11,948,464	378,965	12,327,429		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 & ID Number

DeKalb County Rehab & Nursing

#0044321

Report Period Beginning:

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Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7**	8		
30	Depreciation			644,489	644,489		644,489	(1,575)	642,914		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			211,862	211,862		211,862	(123,865)	87,997		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			52,009	52,009		52,009		52,009		35
36	Other (specify):*										36
37	TOTAL Ownership			908,360	908,360		908,360	(125,440)	782,920		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			517	517		517		517		38
39	Ancillary Service Centers		162,631		162,631		162,631		162,631		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			2,169,095	2,169,095		2,169,095		2,169,095		42
43	Other (specify):* Non-allowable cost			50,877	50,877		50,877	(50,877)			43
44	TOTAL Special Cost Centers		162,631	2,220,489	2,383,120		2,383,120	(50,877)	2,332,243		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,631,711	1,242,823	7,365,410	15,239,944		15,239,944	202,648	15,442,592		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	(9,550)	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	(1,575)	30		9
10	Interest and Other Investment Income	(123,865)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,989)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(27,888)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (191,867)		\$	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)	394,515		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 394,515		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 202,648		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

DeKalb County Rehab & Nursing

ID# 0044321

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing & Public Relations	\$ (4,046)	43	1
2	Medicare lab fees	(13,984)	43	2
3	Medicare radiology fees	(7,650)	43	3
4	Non-Care Real Estate Taxes	(2,208)	43	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(27,888)		49

Facility Name & ID Number DeKalb County Rehab & Nursing

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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, Illinois	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	490,032	DeKalb County, Illinois	100.00%	490,032		2
3	V	22 IMRF	529,693	DeKalb County, Illinois	100.00%	529,693		3
4	V	22 Health Insurance	1,002,633	DeKalb County, Illinois	100.00%	1,002,633		4
5	V	22 Workers Comp	87,181	DeKalb County, Illinois	100.00%	87,181		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		\$ 2,191,539			\$ 2,191,539	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 6,720	\$ 6,720	15
16	V	7 Employee Benefit-Plan		DeKalb County, Illinois	100.00%	21,216	21,216	16
17	V	17 County Board Costs		DeKalb County, Illinois	100.00%	60,241	60,241	17
18	V	19 State's Attorney		DeKalb County, Illinois	100.00%	7,504	7,504	18
19	V	21 Departmental and non-departmental costs		DeKalb County, Illinois	100.00%	215,463	215,463	19
20	V	26 Risk Management		DeKalb County, Illinois	100.00%	20,151	20,151	20
21	V	27 Employee Benefit-G&A		DeKalb County, Illinois	100.00%	63,220	63,220	21
22	V							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		\$			\$ 394,515	\$ * 394,515	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: 01/01/09 Ending: 12/31/09

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	OPERATING BOARD								\$	1	
2	Lynn Stevens	Member	Administrative	0.00	NONE	1	2.00	N/A	0	2	
3	Veronica Casella	Member	Administrative	0.00	NONE	1	2.00	N/A	0	3	
4	John Wilson	Member	Administrative	0.00	NONE	1	2.00	N/A	0	4	
5	Nate Kloster	Member	Administrative	0.00	NONE	1	2.00	N/A	0	5	
6	Ken Andersen	Member	Administrative	0.00	NONE	1	2.00	N/A	0	6	
7	Ron Klein	Member	Administrative	0.00	NONE	1	2.00	N/A	0	7	
8										8	
9										9	
10										10	
11	No Members of the board provide services or received compensation from the nursing home.										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

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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	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	*	*	\$ 6,720			\$ 6,720	1
2	7	Employee Benefits-Plant	*	*	21,216			21,216	2
3	17	County Board Costs	*	*	60,241			60,241	3
4	19	State's Attorney	*	*	7,504			7,504	4
5	21	Departmental and	*	*	215,463			215,463	5
6	26	Risk Management	*	*	20,151			20,151	6
7	27	Employee Benefits-G&A	*	*	63,220			63,220	7
8	30	Depreciation	*	*					8
9									9
10		See Schedule 8A for Method of Allocation							10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 394,515	\$		\$ 394,515	25

SEE ACCOUNTANTS' COMPILATION REPORT

This workpaper is to allocate indirect county cost to the cost report.
As the Maximus report is very costly to update annually, we take the allocated costs from 2007 and inflate them to arrive at our allocated costs. In 2008 we determined a 3% inflation factor was reasonable.
In 2009 we determined a 2% inflation factor was reasonable.

MM 030910

2009 ALLOCATION		Schedule V	
Central Service Dept	Amount	Cost Center	Reference
Non-departmental	33,337	Clerical	21
FICA & IMRF	84,437	EE Benefits	4
Risk Management	20,151	Insurance	26
Facilities Management	6,720	Plant Maint.	6
Finance	152,821	Clerical	21
Information Management	19,783	Clerical	21
Treasurer	9,522	Clerical	21
State's Attorney	7,504	Prof. Fees	19
County Board	60,241	Admin	17
	<u>394,515</u>		

Allocation of FICA & IMRF		Sch V	
Wages from WTB	Wages	Allocation	Reference
Plant	100,148	32,474	7
G&A	160,248	51,963	27
	<u>260,396</u>	<u>84,437</u>	

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.

**Source: Maximum 2007 Indirect Cost Allocation Plan
Schedule A.007 - Page 7 dated 08/08/0/**

2007 ALLOCATION	
Central Service Dept	Amount
Non-departmental	31,731
FICA & IMRF	80,370
Risk Management	19,180
Facilities Management	6,396
Finance	145,461
Information Management	18,830
Treasurer	9,063
State's Attorney	7,143
County Board	57,340
	<u>375,514</u>

**Source: Maximum 2007 Indirect Cost Allocation Plan
Schedule A.007 - Page 7 dated 08/08/0/**

2008 ALLOCATION	
Central Service Dept	Amount
Non-departmental	32,683
FICA & IMRF	82,781
Risk Management	19,755
Facilities Management	6,588
Finance	149,825
Information Management	19,395
Treasurer	9,335
State's Attorney	7,357
County Board	59,060
	<u>386,779</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number DeKalb County Rehab & Nursing # 0044321 Report Period Beginning: 01/01/09 Ending: 12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10						
		Name of Lender					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		Related**	YES											NO	Original			
A. Directly Facility Related																		
Long-Term																		
1	Bonds	X		Facility Construction	Varies	2005	\$ 7,155,000	\$ 4,696,638	2016	0.0520	\$ 211,862	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 7,155,000	\$ 4,696,638			\$ 211,862	9						
B. Non-Facility Related*																		
10								Interest income offset			(123,865)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related										(123,865)	14						
15	TOTALS (line 9+line14)						\$ 7,155,000	\$ 4,696,638			\$ 87,997	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 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.)	2008	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	8	
	2005	9	
	2006	10	
	2007	11	
	2008	N/A	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
County facility - exempt from real estate tax			

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

01/01/09

Ending:

12/31/09**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	\$ 435,516	25	\$ 435,516		\$ 4,282,572	4
5			2000	2000	117,663	4,707	25	4,707		46,281	5
6											6
7											7
8											8
	Improvement Type**										
9		Construction Cap. Rpt cost - new building 3/9/00		1999	12,293	782	10 to 20	782		8,465	9
10		Construction Cap. Rpt cost - new building 3/9/00		2000	10,553	654	15 to 25	654		4,754	10
11		Cap. Rpt. Costs - new building since 3/9/00		2000	37,957	2,297	10 to 25	2,297		21,965	11
12		Maint. Building see fac. Letter and OHF rpt 6/18/01		2000	109,759	5,488	20	5,488		53,965	12
13		Electric,Acoustical duct repair,seal coat dry wall		2001	21,941	830	5 to 24	830		10,106	13
14		Half gate,workstation,swing door,gazebo, & concrete		2001	63,596	4,258	15 to 20	4,258		36,266	14
15		Duct repair,dumpster,slab,stainless steel-kitchen,		2002	10,421	485	5 to 25	485		5,946	15
16		Employee entrance & courtyard landscaping		2003	11,355	1,135	10	1,135		7,273	16
17		Locks on doors, stainless steel walls dietary,lot lights		2004	30,177	2,804	6 to 15	2,804		16,172	17
18		Maint. Mezzanine, replace fire system, fire lane, compressor		2005	24,617	2,775	5 to 20	2,775		12,458	18
19		Architect,construction,painting,programming, dementia unit		2005	339,823	29,700	20	29,700		121,276	19
20		Mirror,painting,replace concrete CVS,replace 29 sprinklers		2006	9,978	969	5 to 18	969		3,403	20
21		Replace 2 doors, add magnets, install magnets & smoke detectors		2006	13,813	1,002	5	1,002		3,269	21
22		Painting in dining rooms		2007	7,840	1,560	5	1,560		3,900	22
23		Replace 600aMP Switch		2007	4,847	373	13	373		1,056	23
24		New Phone System		2007	22,000	2,200	10	2,200		4,767	24
25		New Phone System (Final)		2007	50,589	5,059	10	5,059		10,540	25
26		Steel Doors		2008	3,290	165	20	165		274	26
27		Fencing		2008	21,179	1,412	15	1,412		1,530	27
28		Magnetic Gate		2009	2,887	241	10	241		241	28
29		Upgrade controls		2009	7,904	659	10	659		659	29
30		Wood wrap on Front Columns		2009	6,940	308	15	308		308	30
31		Repair Dietary Floor		2009	7,800	260	20	260		260	31
32		New Door by laundry		2009	5,290	235	15	235		235	32
33		New Canopy in CVS		2009	3,063	119	15	119		119	33
34		New Concrete around building		2009	15,995	444	15	444		444	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

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	To adjust to book depreciation				1,575		(1,575)	66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	11,861,464	\$	508,012	\$	506,437	\$	(1,575)	\$	4,658,502	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,698,790	\$ 134,809	\$ 134,809	\$	5 to 15	\$ 1,255,179	71
72	Current Year Purchases	33,576	1,668	1,668		5	1,668	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,732,366	\$ 136,477	\$ 136,477	\$		\$ 1,256,847	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 Assets

	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)	\$ 13,699,311	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 644,489	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 642,914	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,575)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,937,732	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-Progress

	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 8.

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				N/A			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: \$ 52,009

Description: Nursing Equip-40,217; Postage Meter-378; Copier-9,731; Maintenance Equip-1,595; Other-88

(Attach a schedule detailing the breakdown of movable equipment)

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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?</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>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			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,976	\$ 142,244			\$	1,976	\$ 142,244	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		378	27,246				378	27,246	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A(3)	hrs		5,944	427,938				5,944	427,938	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					162,631			162,631	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			\$	8,298	\$ 597,428		\$ 162,631		8,298	\$ 760,059	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# 0044321Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 535,210	\$ 535,210	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>155,639</u>)	1,953,418	1,953,418	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	3,693,727	3,693,727	5
6	Prepaid Insurance	68,331	68,331	6
7	Other Prepaid Expenses	9,183	9,183	7
8	Accounts Receivable (owners or related parties)	1,254,649	1,254,649	8
9	Other(specify): <u>Sr. Living Facility-Dev.</u>	3,992	3,992	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,518,510	\$ 7,518,510	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,098	83,098	13
14	Buildings, at Historical Cost	12,176,528	11,005,557	14
15	Leasehold Improvements, at Historical Cost	770,828	855,907	15
16	Equipment, at Historical Cost	1,762,609	1,754,749	16
17	Accumulated Depreciation (book methods)	(6,241,300)	(5,937,732)	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>Const in progress</u>)	3,332	3,332	22
23	Other(specify): <u>Reserve for IGT</u>	466,895	466,895	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,021,990	\$ 8,231,806	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,540,500	\$ 15,750,316	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 471,498	\$ 471,498	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	401,986	401,986	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,310	250,310	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	240,427	240,427	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interest Payable & Work Comp</u>	25,025	25,025	36
37	<u>Reserve</u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,389,246	\$ 1,389,246	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,696,638	4,696,638	41
42	Deferred Compensation	381,710	381,710	42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,078,348	\$ 5,078,348	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,467,594	\$ 6,467,594	46
47	TOTAL EQUITY (page 18, line 24)	\$ 10,072,906	\$ 9,282,722	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,540,500	\$ 15,750,316	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,005,755	1
2	Restatements (describe):		2
3	Prior Period Adjustment	247,067	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,252,822	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(241,128)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,061,212	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)	\$ 820,084	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,072,906	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number DeKalb County Rehab & Nursing# 0044321Report Period Beginning: 01/01/09Ending: 12/31/09**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 14,549,986	1
2	Discounts and Allowances for all Levels	(2,490,830)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,059,156	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,383,343	6
7	Oxygen	176,832	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,560,175	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	197,480	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,550	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	280,365	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,985	19
20	Radiology and X-Ray	6,778	20
21	Other Medical Services	380,594	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 891,752	23
D. Non-Operating Revenue			
24	Contributions	26,696	24
25	Interest and Other Investment Income***	123,865	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 150,561	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Maintenance 1,313</u>	1,313	28
28a	<u>Medicaid Count Portion 212,863: donation 102381</u>	335,859	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 337,172	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,998,816	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,332,053	31
32	Health Care	6,707,113	32
33	General Administration	2,909,298	33
B. Capital Expense			
34	Ownership	908,360	34
C. Ancillary Expense			
35	Special Cost Centers	214,025	35
36	Provider Participation Fee	2,169,095	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,239,944	40
41	Income before Income Taxes (line 30 minus line 40)**	(241,128)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (241,128)	43

* 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 Home-No Tax Return Filed

*** 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:

01/01/09

Ending:

12/31/09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,728	2,140	\$ 83,803	\$ 39.16	1
2	Assistant Director of Nursing	1,780	1,951	63,654	32.63	2
3	Registered Nurses	36,357	4,055	1,217,612	300.27	3
4	Licensed Practical Nurses	9,197	10,516	240,039	22.83	4
5	CNAs & Orderlies	163,172	175,997	2,676,936	15.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,195	8,122	124,927	15.38	8
9	Activity Director	1,829	2,140	39,187	18.31	9
10	Activity Assistants	8,639	9,313	90,223	9.69	10
11	Social Service Workers	7,402	8,400	159,488	18.99	11
12	Dietician					12
13	Food Service Supervisor	3,759	4,514	91,265	20.22	13
14	Head Cook	1,780	2,018	28,024	13.89	14
15	Cook Helpers/Assistants	7,090	8,055	95,659	11.88	15
16	Dishwashers	35,460	38,497	363,362	9.44	16
17	Maintenance Workers	5,189	5,711	103,989	18.21	17
18	Housekeepers	20,584	22,460	227,312	10.12	18
19	Laundry	6,731	7,183	68,879	9.59	19
20	Administrator	2,080	2,080	82,911	39.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,633	18,362	181,479	9.88	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 C: See Sch 20	22,903	25,763	692,962	26.90	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	359,508	357,277	\$ 6,631,711 *	\$ 18.56	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	459	\$ 21,312	1(3)	35
36	Medical Director				36
37	Medical Records Consultant	396	7,910	10(3)	37
38	Nurse Consultant	1,291	122,228	10(3)	38
39	Pharmacist Consultant	Monthly	5,601	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	30	1,601	10(3)	44
45	Social Service Consultant	47	573	12(3)	45
46	Other(specify) <u>Mental Health</u>	36	1,994	12(3)	46
47	<u>Dental Consultant</u>	Monthly	900	10(3)	47
48	<u>Utilization Review</u>	Monthly	8,600	10(3)	48
49	TOTAL (lines 35 - 48)	2,259	\$ 170,719		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	780	\$ 34,102	10(3)	50
51	Licensed Practical Nurses	2,579	100,933	10(3)	51
52	Certified Nurse Assistants/Aides	4,465	101,175	10(3)	52
53	TOTAL (lines 50 - 52)	7,824	\$ 236,210		53

SEE ACCOUNTANTS' COMPILATION REPORT

DeKalb Rehab & Nursing Center
Provider #: 0044321
01/010/09 - 12/31/09

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>
Ward Secretary	3,942	4,374	81,537	18.64
Nursing Secretary	2,353	2,705	53,022	19.60
Unit Clerk	2,016	2,151	27,334	12.71
Medicare Case Workers	4,108	4,491	134,277	29.90
Care Plan Coordinator	983	1,454	48,414	33.30
House Supervisor	5,641	6,197	233,961	37.75
Scheduling Coordinator	1,802	2,120	38,784	18.29
Rehab LPN/RN	2,058	2,271	75,633	33.30
	<u>22,903</u>	<u>25,763</u>	<u>692,962</u>	<u>26.90</u>

SEE ACCOUNTANTS' COMPILATION REPORT

DeKalb Rehab & Nursing Center

Provider #: 0044321

01/01/09 - 12/31/09

Schedule 21A

XIX. SUPPORT SERVICES - Section C Professional Services

Per Schedule V, Line 19, Column 3	58,041
Add: Indirect County Allocation	7,504
Less: Non-allowable legal retainers	<u>(6,000)</u>
To Schedule V, Line 19, Column 8	<u><u>59,545</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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number DeKalb County Rehab & Nursing

0044321

Report Period Beginning: 01/01/09

Ending: 12/31/09

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 - 9747
- (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? 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? Yes
What was the average life used for new equipment added during this period? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 72,045 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 2,169,095
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,550
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
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.
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT