

Facility Name & ID Number DeKalb County Rehab & Nrsing

0044321 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	190	Skilled (SNF)	190	69,350	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF	1,077		7,450	8,527	8
9	SNF/PED					9
10	ICF	33,444	20,562		54,006	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,521	20,562	7,450	62,533	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.17%

D. How many bed-hold days during this year were paid by the Department?

N/A (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 7,450

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 - Tax Exempt Fiscal Year: 12/31/14

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

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	590,693	38,869	30,119	659,681		659,681		659,681		1
2	Food Purchase		435,721		435,721		435,721	(4,803)	430,918		2
3	Housekeeping	215,469	53,106	194,080	462,655		462,655		462,655		3
4	Laundry	78,295	11,340		89,635		89,635		89,635		4
5	Heat and Other Utilities			305,591	305,591		305,591	(1,052)	304,539		5
6	Maintenance	115,556	61,615	108,198	285,369		285,369	6,855	292,224		6
7	Other (specify):*										7
8	TOTAL General Services	1,000,013	600,651	637,988	2,238,652		2,238,652	1,000	2,239,652		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	4,427,121	332,314	704,203	5,463,638		5,463,638	(56,117)	5,407,521		10
10a	Therapy	209,904			209,904		209,904		209,904		10a
11	Activities	127,459	6,642	17,695	151,796		151,796		151,796		11
12	Social Services	166,222		643	166,865		166,865		166,865		12
13	CNA Training										13
14	Program Transportation			2,917	2,917		2,917		2,917		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,930,706	338,956	731,458	6,001,120		6,001,120	(56,117)	5,945,003		16
	C. General Administration										
17	Administrative	105,548		157,494	263,042		263,042	61,451	324,493		17
18	Directors Fees										18
19	Professional Services			243,771	243,771		243,771	(10,638)	233,133		19
20	Dues, Fees, Subscriptions & Promotions			67,093	67,093		67,093	(5,884)	61,209		20
21	Clerical & General Office Expenses	185,819	36,453	206,554	428,826		428,826	215,233	644,059		21
22	Employee Benefits & Payroll Taxes			2,270,379	2,270,379		2,270,379	86,131	2,356,510		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,937	1,937		1,937		1,937		24
25	Other Admin. Staff Transportation			1,586	1,586		1,586		1,586		25
26	Insurance-Prop.Liab.Malpractice			46,323	46,323		46,323	20,556	66,879		26
27	Other (specify):*										27
28	TOTAL General Administration	291,367	36,453	2,995,137	3,322,957		3,322,957	366,849	3,689,806		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,222,086	976,060	4,364,583	11,562,729		11,562,729	311,732	11,874,461		29

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

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

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	
	D. Ownership											
30	Depreciation			578,004	578,004	578,004	5,951	583,955				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			98,297	98,297	98,297	(98,297)					32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			75,120	75,120	75,120		75,120				35
36	Other (specify):*											36
37	TOTAL Ownership			751,421	751,421	751,421	(92,346)	659,075				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,165	2,165	2,165		2,165				38
39	Ancillary Service Centers		183,750	694,219	877,969	877,969	(13,882)	864,087				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			434,937	434,937	434,937		434,937				42
43	Other (specify):* Non-Allowable Co			53,975	53,975	53,975	(53,975)					43
44	TOTAL Special Cost Centers		183,750	1,185,296	1,369,046	1,369,046	(67,857)	1,301,189				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,222,086	1,159,810	6,301,300	13,683,196	13,683,196	151,529	13,834,725				45

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

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	(4,803)	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	7,941	30		9
10	Interest and Other Investment Income	(98,297)	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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,520)	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 Page 5A	(128,232)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (250,911)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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)	402,440		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 402,440		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 151,529		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

DeKalb County Rehab & Nrsing

ID# 0044321

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing & Public Relations	\$ (573)	43	1
2	Labs - Part A	(13,643)	43	2
3	X-Rays - Part A	(11,583)	43	3
4	Community Relations	(198)	43	4
5	Disallow Non-Allowable Legal	(18,876)	19	5
6	Disallow Non-Allowable Advertising	(2,999)	20	6
7	Adjust Legal Fees to Invoices	582	19	7
8	Lobbying Offset	(2,885)	20	8
9	Oxygen	(56,117)	10	9
10	Disallow Outpatient Therapy - Ancillary	(13,882)	39	10
11	Disallow Outpatient Therapy - Depreciation	(1,990)	30	11
12	Disallow Outpatient Therapy - Maintenance	(1,052)	5	12
13	Offset Misc. Income	(4,557)	21	13
14	Loss on Disposal	(458)	43	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		(128,232)	49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 Government

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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)	
1	V	21 Department chargeback	\$ 167,500	DeKalb County, Illinois	100.00%	\$ 167,500	\$	1
2	V	22 FICA Taxes	469,485	DeKalb County, Illinois	100.00%	469,485		2
3	V	22 IMRF	672,517	DeKalb County, Illinois	100.00%	672,517		3
4	V	22 Health Insurance	1,183,226	DeKalb County, Illinois	100.00%	1,183,226		4
5	V	22 Workers Comp	(138,203)	DeKalb County, Illinois	100.00%	(138,203)		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		\$ 2,354,525			\$ 2,354,525	\$ * 0	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Maintenance	\$	DeKalb County, Illinois	100.00%	\$ 6,855	\$	6,855	15
16	V	22 Employee Benefit-Plan		DeKalb County, Illinois	100.00%	24,459		24,459	16
17	V	17 County Board Costs		DeKalb County, Illinois	100.00%	61,451		61,451	17
18	V	19 State's Attorney		DeKalb County, Illinois	100.00%	7,656		7,656	18
19	V	21 Departmental and non-departmental costs		DeKalb County, Illinois	100.00%	219,790		219,790	19
20	V	26 Risk Management		DeKalb County, Illinois	100.00%	20,556		20,556	20
21	V	22 Employee Benefit-G&A		DeKalb County, Illinois	100.00%	61,673		61,673	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		\$			\$ 402,440	\$ *	402,440	39

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

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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	OPERATING BOARD										
2	Ron Klein	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	2
3	Veronica Casella	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	3
4	Russell Deverell	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	4
5	Rita Nielsen	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	5
6	Jeff Whelan	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	6
7											7
8											8
9											9
10	No members of the operating board provide services to the county.										
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DeKalb County Rehab & Nrsing

0044321

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	*	*	\$ 6,855			\$	1
2	22	Employee Benefits-Plan	*	*	24,459				2
3	17	County Board Costs	*	*	61,451				3
4	19	State's Attorney	*	*	7,656				4
5	21	Departmental and Non Departme	*	*	219,790				5
6	26	Risk Management	*	*	20,556				6
7	22	Employee Benefits-G&A	*	*	61,673				7
8									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				\$ 402,440	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	Bonds	X		Facility Construction	Varies	2005	\$ 7,155,000	\$ 1,730,388	2016	0.0520	\$ 98,297	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 7,155,000	\$ 1,730,388			\$ 98,297	9					
	B. Non-Facility Related*																
10												10					
11												11					
12											(98,297)	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (98,297)	14					
15	TOTALS (line 9+line14)						\$ 7,155,000	\$ 1,730,388			\$	15					

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DeKalb County Rehab & Nrsing 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 2013 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 2013.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

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

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 6,460,151	4
5		2000	2000	117,663	4,707	25	4,707		69,815	5
6										6
7										7
8										8
Improvement Type**										
9	Construction Cap. Rpt cost - new building 3/9/00		1999	12,293	700	10 to 20	700		12,293	9
10	Construction Cap. Rpt cost - new building 3/9/00		2000	10,553	654	15 to 25	654		8,024	10
11	Cap. Rpt. Costs - new building since 3/9/00		2000	37,957	2,297	10 to 25	2,297		33,450	11
12	Maint. Building see fac. Letter and OHF rpt 6/18/01		2000	109,759	5,488	20	5,488		81,405	12
13	Electric,Acoustical duct repair,seal coat dry wall		2001	21,941	830	5 to 24	830		14,255	13
14	Half gate,workstation,swing door,gazebo, & concrete		2001	63,596	4,258	15 to 20	4,258		57,557	14
15	Duct repair,dumpster,slab,stainless steel-kitchen		2002	10,421	485	5 to 25	485		8,371	15
16	Employee entrance & courtyard landscaping		2003	11,355		10			11,355	16
17	Locks on doors, stainless steel walls dietary,lot lights		2004	30,177	2,789	6 to 15	2,789		30,177	17
18	Maint. Mezzanine, replace fire system, fire lane, compressor		2005	24,617	1,058	5 to 20	1,058		24,617	18
19	Architect,construction,painting,programming, dementia uni		2005	339,823	29,700	20	29,700		269,777	19
20	Mirror,painting,replace concrete CVS,replace 29 sprinklers		2006	9,978	969	5 to 18	969		8,247	20
21	Replace 2 doors, add magnets, install magnets & smoke detector		2006	13,813	1,002	5	1,002		8,280	21
22	Painting in dining rooms		2007	7,840		5			7,840	22
23	Replace 600aMP Switch		2007	4,847	373	13	373		2,921	23
24	New Phone System		2007	22,000	2,200	10	2,200		15,766	24
25	New Phone System (Final)		2007	50,589	5,059	10	5,059		35,834	25
26	Steel Doors		2008	3,290	165	20	165		1,098	26
27	Fencing		2008	21,179	1,412	15	1,412		8,590	27
28	Magnetic Gate		2009	2,887	280	10	280		1,640	28
29	Upgrade controls		2009	7,904	790	10	790		4,610	29
30	Wood wrap on Front Columns		2009	6,940	463	15	463		2,623	30
31	Repair Dietary Floor		2009	7,800	390	20	390		2,210	31
32	New Door by laundry		2009	5,290	353	15	353		1,999	32
33	New Canopy in CVS		2009	3,063	204	15	204		1,139	33
34	New Concrete around building		2009	15,996	1,066	15	1,066		5,774	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number DeKalb County Rehab & Nrsing

0044321

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	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	HD Swing Operator w/ control	2011	\$ 2,841	\$ 284	10	\$ 284	\$	\$ 994	37
38	Replace Fire Eye Controller	2011	3,601	300	12	300		1,050	38
39									39
40	Exit Devices @ CVS Von Duprin	2012	3,651	183	10	183		549	40
41	Exit Devices @ Bldg A Von Duprin	2012	3,651	183	10	183		549	41
42	New Freezer Compressor	2012	5,271	264	10	264		792	42
43	Rebuilt series 80 pumps #1,#2, #3	2012	5,062	253	10	253		759	43
44	Resurfacing Parking Lot	2012	122,272	7,642	8	7,642		22,926	44
45	Gazebo Improvements - Foundation	2012	7,250	967	3.75	967		2,901	45
46									46
47	14x24 Garage Wood-donation	2013	5,870	391	15	391		489	47
48	Replae Module in Fireye Boiler	2013	5,844	584	10	584		1,071	48
49	Rebuild Hot Water Pump in Service	2013	3,755	376	10	376		688	49
50	Replace HW Valve on Air Handler	2013	3,661	366	10	366		671	50
51	Insulation Work On Trane 300 Ton	2013	3,201	213	15	213		320	51
52	Repair Lochinar Boilers	2013	5,153	429	12	429		608	52
53	Replace Parts for 300 Ton Chillers	2013	3,865	258	15	258		344	53
54	Replace Pontentiometer and Switch	2013	4,328	361	12	361		390	54
55	Remodel Admin office for 2 persons	2013	4,500	450	10	450		488	55
56	Hot water Pump #2 Bearing assembly	2013	4,791	479	10	479		559	56
57									57
58	Completion of Potentiometer & Switch in Boiler	2014	3,360	344	10	344		344	58
59	Repair to sprinkler system	2014	3,837	320	12	320		320	59
60	Replace Expansion Valves on Chiller	2014	4,488	224	15	224		224	60
61	Replace boiler #1	2014	4,631	347	10	347		347	61
62	Generator control panel & primer pump	2014	15,502	861	12	861		861	62
63	Replace condenser Fan motor on chiller	2014	4,264	190	15	190		190	63
64	Freezer door in kitchen	2014	4,717	104	7.5	104		104	64
65									65
66	Adjustment to Financial Statements			(7,941)		(1,990)	5,951		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 12,100,830	\$ 511,639		\$ 517,590	\$ 5,951	\$ 7,228,356	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,822,422	\$ 64,017	\$ 64,017	\$	5-20	\$ 1,713,512	71
72	Current Year Purchases	26,816	2,348	2,348		5-10	2,348	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,849,238	\$ 66,365	\$ 66,365	\$		\$ 1,715,860	75

D. Vehicle Costs. (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	Maintenance	1995 GMC Truck	1996	\$ 22,383	\$	\$	\$	5	\$ 22,383	76
77										77
78										78
79										79
80	TOTALS			\$ 22,383	\$	\$	\$		\$ 22,383	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,055,549	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 578,004	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 583,955	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,951	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,966,599	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number DeKalb County Rehab & Nrsing

0044321

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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 N/A.

N/A

N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 75,120 Description: Nursing Equipment \$64,825, Maintenance \$1,330, Copy & Postage Machine \$8,965

(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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	5 Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	3,694	\$ 231,657	\$	3,694	\$ 231,657	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,025	67,048		1,025	67,048	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		4,784	295,859		4,784	295,859	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				183,750		183,750	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapist</u>	39(3)			1,554	85,773		1,554	85,773	12
13	Other (specify):									13
14	TOTAL			\$	11,057	\$ 680,337	\$ 183,750	11,057	\$ 864,087	14

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

Facility Name & ID Number DeKalb County Rehab & Nrsing

0044321

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 923,260	\$ 923,260	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (271,360))	3,672,187	3,672,187	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	3,337,612	3,337,612	5
6	Prepaid Insurance	88,858	88,858	6
7	Other Prepaid Expenses	145,866	145,866	7
8	Accounts Receivable (owners or related parties)			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)	\$ 8,171,775	\$ 8,171,775	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	12,182,398	11,005,557	14
15	Leasehold Improvements, at Historical Cost	1,013,210	1,095,273	15
16	Equipment, at Historical Cost	1,743,065	1,871,621	16
17	Accumulated Depreciation (book methods)	(8,984,105)	(8,966,599)	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 (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,037,666	\$ 5,088,950	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,209,441	\$ 13,260,725	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 635,019	\$ 635,019	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	387,320	387,320	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	98,761	98,761	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interest Payable & Work Comp. Res.</u>	441,666	441,666	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,562,766	\$ 1,562,766	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,730,388	1,730,388	41
42	Deferred Compensation	395,045	395,045	42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,125,433	\$ 2,125,433	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,688,199	\$ 3,688,199	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,521,242	\$ 9,572,526	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,209,441	\$ 13,260,725	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,064,110	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(127,525)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,936,585	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	584,657	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)	\$ 584,657	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)	\$ 10,521,242	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,540,156	1
2	Discounts and Allowances for all Levels	(3,987,497)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,552,659	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,111,864	6
7	Oxygen	148,407	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,260,271	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	158,123	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,803	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	230,690	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,409	19
20	Radiology and X-Ray	15,087	20
21	Other Medical Services	859,478	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,285,590	23
D. Non-Operating Revenue			
24	Contributions	26,097	24
25	Interest and Other Investment Income***	104,174	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 130,271	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See Sch 19A</u>	1,039,062	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,039,062	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,267,853	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,238,652	31
32	Health Care	6,001,120	32
33	General Administration	3,322,957	33
B. Capital Expense			
34	Ownership	751,421	34
C. Ancillary Expense			
35	Special Cost Centers	934,109	35
36	Provider Participation Fee	434,937	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,683,196	40
41	Income before Income Taxes (line 30 minus line 40)**	584,657	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 584,657	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,597,650	44
45	Private Pay - Net Inpatient Revenue	3,793,230	45
46	Medicare - Net Inpatient Revenue	1,161,779	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,552,659	49

* 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.

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

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

^ - County Home - No Tax Return Filed

Facility Name: DeKalb County Rehab & Nrsing
IDPH License ID Number: 0044321
Fiscal Year End: 12/31/14

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

<u>Account #</u>	<u>Description</u>	<u>Amount</u>
01-3980-4138	Medicaid County Portion	1,034,034
01-3980-5626	W/C Salaries Reimbursement	471
01-3980-5899	Miscellaneous	4,557
01-3990-9830	Loss On Disposal Of F\A	(458)
	Total - Line 28	<u><u>1,038,604</u></u>

Facility Name & ID Number DeKalb County Rehab & Nrsing

0044321

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	923	1,165	\$ 85,076	\$ 73.02	1
2	Assistant Director of Nursing	1,728	2,090	37,046	17.73	2
3	Registered Nurses	44,954	49,572	1,421,936	28.68	3
4	Licensed Practical Nurses	12,542	13,415	317,175	23.64	4
5	CNAs & Orderlies	125,954	137,966	1,785,326	12.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,404	10,506	209,904	19.98	8
9	Activity Director	1,930	2,233	42,961	19.24	9
10	Activity Assistants	9,355	10,242	84,498	8.25	10
11	Social Service Workers	7,234	8,401	166,222	19.79	11
12	Dietician	1,891	2,180	53,992	24.77	12
13	Food Service Supervisor	2,342	2,717	48,729	17.94	13
14	Head Cook	1,771	1,923	25,137	13.07	14
15	Cook Helpers/Assistants	6,450	7,363	79,425	10.79	15
16	Dishwashers	38,253	41,737	383,410	9.19	16
17	Maintenance Workers	5,076	5,987	115,556	19.30	17
18	Housekeepers	19,724	21,580	215,469	9.98	18
19	Laundry	6,557	7,845	78,295	9.98	19
20	Administrator	2,080	2,080	105,548	50.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,134	14,342	185,819	12.96	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 20A	30,238	33,779	780,562	23.11	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	343,539	377,122	\$ 6,222,086 *	\$ 16.50	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	597	\$ 30,119	1(3)	35
36	Medical Director	53	6,000	9(3)	36
37	Medical Records Consultant	375	8,088	10(3)	37
38	Nurse Consultant	Monthly	5,439	10(3)	38
39	Pharmacist Consultant	Flat Fee	14,415	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	58	2,589	11(3)	44
45	Social Service Consultant	8	643	12(3)	45
46	Other(specify)				46
47					47
48	Other - See Sch 20B		925	10(3)	48
49	TOTAL (lines 35 - 48)	1,091	\$ 68,218		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,305	\$ 57,454	10(3)	50
51	Licensed Practical Nurses	2,424	105,063	10(3)	51
52	Certified Nurse Assistants/Aides	23,393	512,819	10(3)	52
53	TOTAL (lines 50 - 52)	27,122	\$ 675,336		53

Facility Name: DeKalb County Rehab & Nrsing
IDPH License ID Number: 0044321
Fiscal Year End: 12/31/14

Schedule 20A

XVIII. Staffing and Salary Costs

Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Inservice Instructor	445	445	12,151	\$ 27.29
Care Plan Coordinator	1,883	2,141	68,650	\$ 32.07
House Supervisor	4,016	4,539	171,717	\$ 37.83
Scheduling Coord	1,872	2,108	40,179	\$ 19.06
Clinical & Support Services Coordinator	1,096	1,102	27,507	\$ 24.96
CVS Department Head	1,569	2,049	65,122	\$ 31.79
Unit Clerk and Assistant	8,664	9,308	100,723	\$ 10.82
Medicare Case Manager	4,230	4,737	149,414	\$ 31.55
Nursing Secretary	2,379	2,677	54,178	\$ 20.24
Ward Secretary	4,085	4,675	90,920	\$ 19.45
Total - Line 32 Other Health Care (specify):	30,238	33,779	780,562	\$ 23.11

Facility Name: DeKalb County Rehab & Nrsing
IDPH License ID Number: 0044321
Fiscal Year End: 12/31/14

Schedule 20B

XVIII. Consultant Services
Line 48 Other:

Description	# of Hrs. Paid & Accrued	Total Consultant s	Schedule V Line & Column Reference
Nursing Dental Consult	Flat Fee	900	10 (3)
Nursing Utilization Rev	Monthly	25	10 (3)
Total - Line 48 Other:	-	925	

Facility Name: DeKalb County Rehab & Nrsing
IDPH License ID Number: 0044321
Fiscal Year End: 12/31/14

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>	
McGladrey LLP	Accounting	11,925	
Laner Muchin Dombrow Becker Levin & Tomi	Legal	6,147	
Polsinelli Shughart PC	Legal	27,223	
Myers Carden & Sax LLC	Legal	37,294	
Stricklin & Associates	Legal	8,000	
Foster & Buick	Legal	10,146	
Pinnacle Consulting	Operations Consultant	4,375	
Management Performance Association	Operations Consultant	41,460	
Management Performance Association	Operations Consultant	40,600	
Management Performance Association	Operations Consultant	12,501	
Helen Turner	CPR Instructor	2,600	89,392
Larson & Darby Group	Architect	41,500	
	Total (agree to Schedule V, line 19, column 3)	<u>243,771</u>	
	Adjustment to Add Invoices Legal Fees	582	
	Allocated from Management Company Professional Services	8,292	
	Less: Non-Allowable Legal Fees	(18,876)	
	Total (agree to Schedule V, line 19, column 8)	<u>233,769</u>	

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3											N/A	
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number DeKalb County Rehab & Nrsing

0044321

Report Period Beginning:

01/01/14

Ending:

12/31/14

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 - \$5,129
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 8 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 73,607 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. \$ 434,937
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,803
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.