

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0044321

Facility Name: DeKalb Rehab & Nursing Center

Address: 2600 N. Annie Glidden Rd. DeKalb 60115
Number City Zip Code

County: DeKalb

Telephone Number: (815) 758-2477 Fax # (815) 217-0451

HFS ID Number:

Date of Initial License for Current Owners: 7/15/54

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT
☐ Charitable Corp.
☐ Trust

IRS Exemption Code

☐ PROPRIETARY
☒ GOVERNMENTAL
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

In the event there are further questions about this report, please contact:
Name: Michael W. Martin Telephone Number: (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) SEE ACCOUNTANTS' PREPARATION REPORT	
	(Date) _____	
	(Print Name and Title) _____	
	(Firm Name & Address) McGladrey & Pullen, LLP 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173	
	(Telephone) (847) 517-7070 Fax # (847) 517-7067	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number DeKalb Rehab & Nursing Center

0044321 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,897</u>	<u>52</u>	<u>9,341</u>	<u>11,290</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF	<u>34,177</u>	<u>18,882</u>		<u>53,059</u>	<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>36,074</u>	<u>18,934</u>	<u>9,341</u>	<u>64,349</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.79%

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 9,341

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: N/A Fiscal Year: N/A
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DeKalb Rehab & Nursing Center # 0044321 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	593,323	47,264	26,362	666,949		666,949		666,949			1
2	Food Purchase		587,631		587,631		587,631	(10,126)	577,505			2
3	Housekeeping	215,819	65,951	214,595	496,365		496,365		496,365			3
4	Laundry	90,277	10,786		101,063		101,063		101,063			4
5	Heat and Other Utilities			315,035	315,035		315,035		315,035			5
6	Maintenance	107,979	58,199	114,112	280,290		280,290	10,746	291,036			6
7	Other (specify):* Alloc fica/imrf-Plant							25,015	25,015			7
8	TOTAL General Services	1,007,398	769,831	670,104	2,447,333		2,447,333	25,635	2,472,968			8
	B. Health Care and Programs											
9	Medical Director			112,633	112,633		112,633		112,633			9
10	Nursing and Medical Records	4,741,239	379,166	517,418	5,637,823		5,637,823		5,637,823			10
10a	Therapy	182,595		738,599	921,194		921,194		921,194			10a
11	Activities	136,407	5,458	19,409	161,274		161,274		161,274			11
12	Social Services	163,695		1,094	164,789		164,789		164,789			12
13	CNA Training											13
14	Program Transportation			3,311	3,311		3,311		3,311			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,223,936	384,624	1,392,464	7,001,024		7,001,024		7,001,024			16
	C. General Administration											
17	Administrative	83,012		182,570	265,582		265,582	63,289	328,871			17
18	Directors Fees											18
19	Professional Services			66,889	66,889		66,889	1,684	68,573			19
20	Dues, Fees, Subscriptions & Promotions			57,295	57,295		57,295		57,295			20
21	Clerical & General Office Expenses	191,935	31,210	176,782	399,927		399,927	226,366	626,293			21
22	Employee Benefits & Payroll Taxes			2,374,807	2,374,807		2,374,807		2,374,807			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,876	7,876		7,876		7,876			24
25	Other Admin. Staff Transportation			1,619	1,619		1,619		1,619			25
26	Insurance-Prop.Liab.Malpractice			33,571	33,571		33,571	21,171	54,742			26
27	Other (specify):* Alloc fica/imrf-Plant							63,694	63,694			27
28	TOTAL General Administration	274,947	31,210	2,901,409	3,207,566		3,207,566	376,204	3,583,770			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,506,281	1,185,665	4,963,977	12,655,923		12,655,923	401,839	13,057,762			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	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			570,332	570,332		570,332	34,908	605,240			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			185,039	185,039		185,039	(76,578)	108,461			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			70,853	70,853		70,853		70,853			35
36	Other (specify):*											36
37	TOTAL Ownership			826,224	826,224		826,224	(41,670)	784,554			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,148	1,148		1,148		1,148			38
39	Ancillary Service Centers		269,436		269,436		269,436		269,436			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):* Non-Allow Costs			57,139	57,139		57,139	(57,139)				43
44	TOTAL Special Cost Centers		269,436	162,312	431,748		431,748	(57,139)	374,609			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,506,281	1,455,101	5,952,513	13,913,895		13,913,895	303,030	14,216,925			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,126)	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	34,908	30		9
10	Interest and Other Investment Income	(76,578)	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	(6,200)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,614)	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 Pg 5A	(35,839)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (111,449)		\$	30

BHF USE ONLY							
48		49		50		51	

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 Amount	2 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)	414,479		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 414,479		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 303,030		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 Yes	2 No	3 Amount	4 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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing & Public Relations	\$ (1,782)	43	1
2	Medicare lab fees		43	2
3	Medicare radiology fees		43	3
4	Community Relations	(5,177)	43	4
5	Nonallowable Legal Fees		19	5
6	Labs - Part A	(17,641)	43	6
7	X-Rays - Part A	(14,478)	43	7
8	Special accomodation due to storm	(447)	43	8
9	R&M Reclass	3,686	6	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	(35,839)		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.

1OWNERS		2RELATED NURSING HOMES		3OTHER 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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Department chargeback	\$ 144,000	DeKalb County, Illinois	100.00%	\$ 144,000		1
2	V	22	FICA Taxes	477,556	DeKalb County, Illinois	100.00%	477,556		2
3	V	22	IMRF	577,052	DeKalb County, Illinois	100.00%	577,052		3
4	V	22	Health Insurance	936,198	DeKalb County, Illinois	100.00%	936,198		4
5	V	22	Workers Comp	250,357	DeKalb County, Illinois	100.00%	250,357		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			\$ 2,385,163			\$ 2,385,163	\$ *	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%	\$ 7,060	\$ 7,060	15
16	V	7	Employee Benefit-Plan		DeKalb County, Illinois	100.00%	25,015	25,015	16
17	V	17	County Board Costs		DeKalb County, Illinois	100.00%	63,289	63,289	17
18	V	19	State's Attorney		DeKalb County, Illinois	100.00%	7,884	7,884	18
19	V	21	Departmental and non-departmental costs		DeKalb County, Illinois	100.00%	226,366	226,366	19
20	V	26	Risk Management		DeKalb County, Illinois	100.00%	21,171	21,171	20
21	V	27	Employee Benefit-G&A		DeKalb County, Illinois	100.00%	63,694	63,694	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			\$			\$ 414,479	\$ * 414,479	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 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	Veronica Casella	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	2
3	Ron Klein	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	3
4	Ken Anderson	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	4
5	John Wilson	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	5
6	Lynn Shepard	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number DeKalb Rehab & Nursing Center # 0044321 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	*	*	*	\$ 7,060	\$		\$ 7,060	1
2	7	Employee Benefits-Plant	*	*	*	25,015			20,558	2
3	17	County Board Costs	*	*	*	63,289			63,289	3
4	19	State's Attorney	*	*	*	7,884			7,884	4
5	21	Departmental and	*	*	*	226,366			226,366	5
6	26	Risk Management	*	*	*	21,171			21,171	6
7	27	Employee Benefits-G&A	*	*	*	63,694			68,151	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					\$ 414,479	\$		\$ 414,479	25

Sch 8A

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. In 2010 we determined a 3% inflation factor was reasonable. In 2011 we determined a 2% inflation f

Per Discussion with MM
KP 04/24/11

2011 ALLOCATION		Schedule V	
Central Service Dept	Amount	Cost Center	Reference
Non-departmental	35,024	Clerical	21
FICA & IMRF	88,709	EE Benefits	1
Risk Management	21,171	Insurance	26
Facilities Management	7,060	Plant Maint.	6
Finance	160,554	Clerical	21
Information Management	20,784	Clerical	21
Treasurer	10,004	Clerical	21
State's Attorney	7,884	Prof. Fees	19
County Board	63,289	Admin	17
	414,479		

Allocation of FICA & IMRF		Sch V	
	Wages from WTB	Wages	Allocation Reference
	Plant	107,979	25,015
	G&A	274,947	63,695
		382,926	88,710

Amounts - 3% annual inflation factor based on 2007 Allocation from Maximus Report
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.

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
	375,514

2008 ALLOCATION	
Central Service Dept	Amount
Non-departm	32,683
FICA & IMRF	82,781
Risk Manage	19,755
Facilities Ma	6,588
Finance	149,825
Information I	19,395
Treasurer	9,335
State's Attorr	7,357
County Boar	59,060
	386,779

2009 ALLOCATION	
Central Service Dept	Amount
Non-departmental	33,337
FICA & IMRF	84,437
Risk Management	20,151
Facilities Management	6,720
Finance	152,821
Information Management	19,783
Treasurer	9,522
State's Attorney	7,504
County Board	60,241
	394,515

2010 ALLOCATION	
Central Service Dept	Amount
Non-departm	34,337
FICA & IMRF	86,970
Risk Manage	20,756
Facilities Ma	6,922
Finance	157,406
Information I	20,376
Treasurer	9,808
State's Attorr	7,729
County Boar	62,048
	406,352

2011 ALLOCATION	
Central Service Dept	Amount
Non-departmental	35,024
FICA & IMRF	88,709
Risk Management	21,171
Facilities Management	7,060
Finance	160,554
Information Management	20,784
Treasurer	10,004
State's Attorney	7,884
County Board	63,289
	414,479

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Bonds	X		Facility Construction	Varies	2005	\$ 7,155,000	\$ 3,579,138	2016	0.0520	\$ 185,039	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 7,155,000	\$ 3,579,138			\$ 185,039	9
	B. Non-Facility Related*											
10								Interest Income Offset			(76,578)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (76,578)	14
15	TOTALS (line 9+line14)						\$ 7,155,000	\$ 3,579,138			\$ 108,461	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.)

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

B. Real Estate Taxes

[illegible]

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.

FACILITY NAME	DeKalb Rehab & Nursing Center	COUNTY	DeKalb
---------------	-------------------------------	--------	--------

CONTACT PERSON REGARDING THIS REPORT Doreen Akers

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Ex Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

SEE ACCOUNTANTS' COMPILATION REPORT

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: N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number DeKalb Rehab & Nursing Center

0044321

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	190		2000	2000	\$ 10,887,894	\$ 435,516	25	\$ 435,516		\$ 5,153,603	4
5			2000	2000	117,663	4,707	25	4,707		55,694	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		10,029	9
10	Construction Cap. Rpt cost - new building 3/9/00			2000	10,553	654	15 to 25	654		6,062	10
11	Cap. Rpt. Costs - new building since 3/9/00			2000	37,957	2,297	10 to 25	2,297		26,559	11
12	Maint. Building see fac. Letter and OHF rpt 6/18/01			2000	109,759	5,488	20	5,488		64,941	12
13	Electric,Acoustical duct repair,seal coat dry wall			2001	21,941	830	5 to 24	830		11,766	13
14	Half gate,workstation,swing door,gazebo, & concrete			2001	63,596	4,258	15 to 20	4,258		44,782	14
15	Duct repair,dumpster,slab,stainless steel-kitchen,			2002	10,421	485	5 to 25	485		6,916	15
16	Employee entrance & courtyard landscaping			2003	11,355	1,135	10	1,135		9,543	16
17	Locks on doors, stainless steel walls dietary,lot lights			2004	30,177	2,804	6 to 15	2,804		21,780	17
18	Maint. Mezzanine, replace fire system, fire lane, compressor			2005	24,617	2,775	5 to 20	2,775		18,009	18
19	Architect,construction,painting,programming, dementia unit			2005	339,823	29,700	20	29,700		180,676	19
20	Mirror,painting,replace concrete CVS,replace 29 sprinklers			2006	9,978	969	5 to 18	969		5,340	20
21	Replace 2 doors, add magnets, install magnets & smoke detectors			2006	13,813	1,002	5	1,002		5,273	21
22	Painting in dining rooms			2007	7,840	1,560	5	1,560		7,020	22
23	Replace 600aMP Switch			2007	4,847	373	13	373		1,802	23
24	New Phone System			2007	22,000	2,200	10	2,200		9,167	24
25	New Phone System (Final)			2007	50,589	5,059	10	5,059		20,657	25
26	Steel Doors			2008	3,290	165	20	165		604	26
27	Fencing			2008	21,179	1,412	15	1,412		4,354	27
28	Magnetic Gate			2009	2,887	280	10	280		800	28
29	Upgrade controls			2009	7,904	790	10	790		2,239	29
30	Wood wrap on Front Columns			2009	6,940	463	15	463		1,234	30
31	Repair Dietary Floor			2009	7,800	390	20	390		1,040	31
32	New Door by laundry			2009	5,290	353	15	353		941	32
33	New Canopy in CVS			2009	3,063	204	15	204		527	33
34	New Concrete around building			2009	15,995	1,066	15	1,066		2,576	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.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	HD Swing Operator w/ control	2011	\$ 2,841	\$ 142	10	\$ 142	\$ 0	\$ 142	37
38	Replace Fire Eye Controller	2011	3,601	150	12	150	0	150	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,867,905	\$ 508,009		\$ 508,009	\$ 0	\$ 5,674,227	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	\$1,766,404	\$61,830	\$96,739	\$34,909	5-15	\$1,449,549	71
72	Current Year Purchases	4,919	492	492		5-15	492	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,771,323	\$62,322	\$97,231	\$34,909		\$1,450,041	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	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)	\$13,744,70981
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$570,33182
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$605,24083
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$34,90984
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,146,65185

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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease 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: \$ 70,853 Description: Nursing Equipment \$58,984; Maintenance \$1,058; Other Equipment \$10,811
(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			\$ N/A	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year EndingAnnual Rent
12. /2012 \$
13. /2013 \$
14. /2014 \$

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	4,202	\$ 302,578	\$	4,202	\$ 302,578	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,118	80,479		1,118	80,479	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,938	355,428		4,938	355,428	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				269,436		269,436	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			\$	10,258	\$ 738,485	\$ 269,436	10,258	\$ 1,007,921	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.

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	\$ 30,967	\$ 30,967	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 208,075)	5,151,869	5,151,869	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,454,898	1,454,898	5
6	Prepaid Insurance	82,297	82,297	6
7	Other Prepaid Expenses	92,855	92,855	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Sr. Living Facility - Dev.	3,992	3,992	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,816,878	\$ 6,816,878	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	782,515	862,348	15
16	Equipment, at Historical Cost	1,756,707	1,793,706	16
17	Accumulated Depreciation (book methods)	(7,354,112)	(7,146,651)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	3,332	3,332	22
23	Other(specify): Reserve for IGT	2,294,098	2,294,098	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,742,166	\$ 8,895,488	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,559,044	\$ 15,712,366	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 490,614	\$ 490,614	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	385,595	385,595	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	302,164	302,164	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	198,918	198,918	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interest Payable & Work Comp. Res.	418,928	418,928	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,796,219	\$ 1,796,219	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,579,138	3,579,138	41
42	Deferred Compensation	375,677	375,677	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,954,815	\$ 3,954,815	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,751,034	\$ 5,751,034	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,808,010	\$ 9,961,332	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,559,044	\$ 15,712,366	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,220,505	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(201,215)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,019,290	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	788,720	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)	\$ 788,720	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)	\$ 10,808,010	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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,328,699	1
2	Discounts and Allowances for all Levels	(5,797,465)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,531,234	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,357,424	6
7	Oxygen	235,935	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,593,359	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	178,922	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,126	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	320,000	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,124	19
20	Radiology and X-Ray	15,159	20
21	Other Medical Services	588,099	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,131,430	23
	D. Non-Operating Revenue		
24	Contributions	75,471	24
25	Interest and Other Investment Income***	76,578	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 152,049	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Sch 19A	1,294,543	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,294,543	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,702,615	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,447,333	31
32	Health Care	7,001,024	32
33	General Administration	3,207,566	33
	B. Capital Expense		
34	Ownership	826,224	34
	C. Ancillary Expense		
35	Special Cost Centers	327,723	35
36	Provider Participation Fee	104,025	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,913,895	40
41	Income before Income Taxes (line 30 minus line 40)**	788,720	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 788,720	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.

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

DeKalb Rehab & Nursing Center
Provider #: 0044321
01/01/11 - 12/31/11

Schedule 19A

28a.

Revenue	Amount
M/C Cost Report Settlement	41,686
Medicaid County Portion	1,048,803
Maintenance	925
Donation	200,000
Miscellaneous	3,129
Total Other Revenue	1,294,543

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,814	2,040	\$ 80,003	\$ 39.22	1
2	Assistant Director of Nursing	1,918	2,023	63,688	31.48	2
3	Registered Nurses	42,967	48,314	1,456,059	30.14	3
4	Licensed Practical Nurses	9,364	10,062	221,016	21.97	4
5	CNAs & Orderlies	139,136	151,505	2,014,685	13.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,995	7,914	182,595	23.07	8
9	Activity Director	1,809	2,115	38,653	18.28	9
10	Activity Assistants	8,654	9,515	97,754	10.27	10
11	Social Service Workers	7,335	8,310	163,695	19.70	11
12	Dietician	1,915	2,141	50,221	23.46	12
13	Food Service Supervisor	2,394	2,667	46,836	17.56	13
14	Head Cook	1,665	2,017	28,492	14.13	14
15	Cook Helpers/Assistants	5,426	6,014	62,812	10.44	15
16	Dishwashers	39,437	43,346	404,962	9.34	16
17	Maintenance Workers	5,162	5,832	107,979	18.52	17
18	Housekeepers	21,349	23,249	215,819	9.28	18
19	Laundry	6,227	7,357	90,277	12.27	19
20	Administrator	2,080	2,080	83,012	39.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,239	15,423	191,935	12.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care <u>Refer sch 20 A</u>	34,666	39,028	905,788	23.21	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	354,551	390,951	\$ 6,506,281 *	\$ 16.64	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	552	\$ 26,362	1(3)	35
36	Medical Director	434	112,633	9(3)	36
37	Medical Records Consultant	339	6,780	10(3)	37
38	Nurse Consultant	Monthly	3,900	10(3)	38
39	Pharmacist Consultant	Falt fess	10,805	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	13	958	11(3)	44
45	Social Service Consultant	83	1,094	12(3)	45
46	Other(specify) <u>Mental Health</u>			12(3)	46
47	<u>Assistant Activities Consultant</u>			10(3)	47
48	<u>Others- refer pg 20B</u>		9,164		48
49	TOTAL (lines 35 - 48)	1,421	\$ 171,696		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,624	\$ 71,896	10(3)	50
51	Licensed Practical Nurses	4,594	182,089	10(3)	51
52	Certified Nurse Assistants/Aides	11,012	232,898	10(3)	52
53	TOTAL (lines 50 - 52)	17,230	\$ 486,883		53

DeKalb Rehab & Nursing Center
Provider #: 0044321
01/01/11- 12/31/11

Schedule 20A

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

Description	Hours Worked	Hours Paid	Salary	Ave. Hrly. Wage
Care Plan Coordinator	1,983	2,059	64,087	31.13
House Supervisor	4,574	5,005	192,751	38.51
Scheduling Coord	1,839	2,159	39,525	18.31
Rehab LPN/RN	2,135	2,452	58,898	24.02
Clinical & Support Services Coordinator	1,577	2,145	77,634	36.19
CVS Department Head	1,558	1,891	63,922	33.80
Unit Clerk and Assistant	9,895	10,902	115,450	10.59
Medicare Case Manager	4,532	4,866	150,028	30.83
Nursing Secretary	2,380	2,584	50,917	19.70
Ward Secretary	4,193	4,965	92,576	18.65
	34,666	39,028	905,788	23.21

DeKalb Rehab & Nursing Center
Provider #: 0044321
01/01/11- 12/31/11

SCH 20B

	1	2	3
	Number of Hrs. Paid & Accrued	Cost for Reporting Period	Schedule V Line & Column Reference
Others			
Nursing dental consultant	Flat Fee	1,050	10(3)
Nursing utilization review	Monthly	8,000	10(3)
Rehab Professional services	2	<u>114</u>	1A(3)
Total		<u><u>9,164</u></u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Catherine Anderson	Administrator	0	\$ 83,012	Workers' Compensation Insurance	\$ 250,357	IDPH License Fee	\$		
				Unemployment Compensation Insurance	24,642	Advertising: Employee Recruitment	40,191		
				FICA Taxes	477,556	Health Care Worker Background Check			
				Employee Health Insurance	936,198	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks	351.6 4,219		
				Illinois Municipal Retirement Fund (IMRF)*	577,052	Life Services Network of Illinois dues	6,947		
				Tort & Liability Fund (Work Comp)	25,116	Vision Share			
				Work Comp Salaries	34,626	Miscellaneous Dues & Subscriptions	2,567		
				Uniform Allowance	21,168	HealthCare Information Subscription			
				Employee Medical Expense	3,636	AAHSA Dues	3,371		
				Employee Life Insurance	24,456	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 2,374,807	TOTAL (agree to Sch. V, line 20, col. 8)			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Performance Association			\$ 182,570	N/A			Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	7,876	
C. Professional Services							See Attached Schedule G		
Vendor/Payee	Type		Amount						
Laner Muchin Dombrow Becker Lev	Legal		\$ 7,102						
Polsinelli Shughart	Legal		756						
McGladrey & Pullen	Accounting		26,445						
Provinet	Service		32,086						
Sikich LLP	Legal		500						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				Entertainment Expense	()
			\$ 66,889				(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 7,876	

*** Attach copy of IMRF notifications**

****See instructions.**

DeKalb Rehab & Nursing Center
Provider #: 0044321
01/01/11 - 12/31/11

Schedule 21A

XIX. SUPPORT SERVICES - Section C Professional Services

Per Schedule V, Line 19, Column 3	66,889
Add: Indirect County Allocation	7,884
Less: Non-allowable legal retainers	<u>(6,200)</u>
To Schedule V, Line 19, Column 8	<u><u>68,573</u></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	Amount of Expense Amortized Per Year								
					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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 - \$6,947
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 81,113 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. \$ 104,025
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,126
- (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? No
Attach invoices and a summary of services for all architect and appraisal fees

RECONCILIATION REPORT			DeKalb Rehab & Nursir		09:16 AM	5/30/2012								
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.	
Adjustment Detail	303,030	equal to	303,030	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7	
Interest Expense	108,461	equal to	108,461	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8	
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8	
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8	
Ownership Costs-Depreciation	605,240	equal to	605,240	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8	
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8	
Rental Costs B	70,853	equal to	70,853	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8	
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8	
Special Serv.- Staff Wages		equal to	0	#VALUE!	#VALUE!	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1	
Therapy Services(B)	738,485	equal to	921,194	-182,709	FAILED	Pg16 Z12+Z14..	N/A,B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4	
Special Serv.- Supplies	269,436	equal to	269,436	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2	
Income Stat. General Serv.	2,447,333	equal to	2,447,333	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4	
Income Stat. Health Care	7,001,024	equal to	7,001,024	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4	
Income Stat. Administation	3,207,566	equal to	3,207,566	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4	
Income Stat. Ownership	826,224	equal to	826,224	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4	
Income Stat. Special Cost Ctr	327,723	equal to	327,723	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+	N/A	38to41+43	4	
Income Stat. Prov. Partic.	104,025	equal to	104,025	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4	
Staff- Nursing (A)	4,018,046	equal to	4,741,239	-723,193	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1	
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1	
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1	
Staff- Activities	136,407	equal to	136,407	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1	
Staff- Social Serv. Workers	163,695	equal to	163,695	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1	
Staff- Dietary	593,323	equal to	593,323	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1	
Staff- Maintenance	107,979	equal to	107,979	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1	
Staff- Housekeeping	215,819	equal to	215,819	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1	
Staff- Laundry	90,277	equal to	90,277	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1	
Staff- Administrative	83,012	equal to	83,012	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1	
Staff- Clerical	191,935	equal to	191,935	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1	
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1	
Total Salaries And Wages	6,506,281	equal to	6,506,281	0	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1	
Dietary Consultant	26,362	< or = to	26,362	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3	
Medical Director	112,633	< or = to	112,633	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3	
Consultants & contractors	508,368	< or = to	517,418	-9,050	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3	
Activity Consultant	958	< or = to	19,409	-18,451	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3	
Social Service Consultant	1,094	< or = to	1,094	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3	
Supp. Sched.- Admin. Salar.	83,012	equal to	83,012	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1	
Supp. Sched.- Admin. Other	182,570	equal to	182,570	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3	
Supp. Sched.- Prof. Serv.	66,889	equal to	66,889	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3	
Supp. Sched.- Benefit/Taxes	2,374,807	equal to	2,374,807	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8	
Supp. Sched.- Sched of dues..	57,295	equal to	57,295	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8	
Supp. Sched.- Sched. of trav	7,876	equal to	7,876	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8	
Gen. Info - Particip. Fees	104,025	equal to	104,025	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3	
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7	
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A	
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1	
Days of medicare provided	9,341	equal to	9,341	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4	
Adjustment for related org. costs	414,479	equal to	414,479	0	FAILED	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8	
Total loan balance	3,579,138	equal to	3,579,138	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2	
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2	
Land	83,098	equal to	83,098	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2	
Building cost	11,867,905	equal to	11,867,905	0	FAILED	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2	
Equipment and vehicle cost	1,793,706	equal to	1,793,706	0	FAILED	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2	
Accumulated depr.	7,146,651	equal to	7,146,651	0	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2	
End of year equity	10,808,010	equal to	10,808,010	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1	
Net income (loss)	788,720	equal to	788,720	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2	
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..J	H.	20	3	Pg17 K30	N/A	18	2	
Balance Sheet	16,559,044	equal to	16,559,044	0	O.K.	Pg17 H41		25	1	Pg17 S41	N/A	48	1	

(A) The difference is due to Line 32 not being included in the calculation.

(B) The difference is due to actual rehab salaries not being included in the special services amounts on page 16.

Rounding off difference