FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0044321

Facility Name: DeKalb County Rehab & Nursing

Address: 2600 North Annie Glidden Road (Number) DeKalb (City) 60115 (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		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/12 to 12/31/12 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) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey 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 County Rehab & Nursing # 0044321 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	190	Skilled (SNF)	190	69,540	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,540	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,845	31	9,309	11,185	8
9	SNF/PED					9
10	ICF	36,212	15,314		51,526	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,057	15,345	9,309	62,711	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.18%

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 [X] 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 [X]

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 190 and days of care provided 9,309

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: N/A Fiscal Year: N/A

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

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

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	605,292	48,241	28,382	681,916		681,916		681,916			1
2	Food Purchase		523,132		523,132		523,132	(8,499)	514,633			2
3	Housekeeping	236,752	61,190	220,775	518,717		518,717		518,717			3
4	Laundry	70,355	9,550		79,905		79,905		79,905			4
5	Heat and Other Utilities			287,366	287,366		287,366		287,366			5
6	Maintenance	117,300	54,613	110,651	282,565		282,565	7,202	289,767			6
7	Other (specify):* Alloc FICA/IMRF-Pl							28,223	28,223			7
8	TOTAL General Services	1,029,700	696,727	647,174	2,373,601		2,373,601	26,927	2,400,527			8
	B. Health Care and Programs											
9	Medical Director			35,413	35,413		35,413		35,413			9
10	Nursing and Medical Records	4,702,207	348,324	514,452	5,564,983		5,564,983		5,564,983			10
10a	Therapy	182,549			182,549		182,549		182,549			10a
11	Activities	140,803	8,858	22,390	172,050		172,050		172,050			11
12	Social Services	166,939		658	167,597		167,597		167,597			12
13	CNA Training											13
14	Program Transportation			3,477	3,477		3,477		3,477			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,192,497	357,182	576,389	6,126,069		6,126,069		6,126,069			16
	C. General Administration											
17	Administrative	83,169		165,673	248,842		248,842	64,555	313,397			17
18	Directors Fees											18
19	Professional Services			155,182	155,182		155,182	1,495	156,677			19
20	Dues, Fees, Subscriptions & Promotions			42,871	42,871		42,871	(2,947)	39,924			20
21	Clerical & General Office Expenses	175,591	23,588	191,500	390,679		390,679	230,893	621,572			21
22	Employee Benefits & Payroll Taxes			2,395,166	2,395,166		2,395,166		2,395,166			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,304	6,304		6,304		6,304			24
25	Other Admin. Staff Transportation			1,195	1,195		1,195		1,195			25
26	Insurance-Prop.Liab.Malpractice			33,830	33,830		33,830	21,595	55,425			26
27	Other (specify):* Alloc FICA/IMRF-Ac							62,260	62,260			27
28	TOTAL General Administration	258,760	23,588	2,991,721	3,274,069		3,274,069	377,851	3,651,920			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,480,958	1,077,497	4,215,284	11,773,739		11,773,739	404,778	12,178,516			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.

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

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			563,262	563,262		563,262	51,548	614,810			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			148,734	148,734		148,734	(61,178)	87,556			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			78,015	78,015		78,015		78,015			35
36	Other (specify):*											36
37	**TOTAL Ownership**			790,011	790,011		790,011	(9,630)	780,381			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,304	1,304		1,304		1,304			38
39	Ancillary Service Centers		132,639	742,926	875,565		875,565		875,565			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			674,064	674,064		674,064		674,064			42
43	Other (specify):* **Non-Allowable Cos**			107,331	107,331		107,331	(107,331)	(0)			43
44	**TOTAL Special Cost Centers**		132,639	1,525,624	1,658,264		1,658,264	(107,331)	1,550,933			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,480,958	1,210,136	6,530,919	14,222,014		14,222,014	287,817	14,509,830			45

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

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

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	(8,499)	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	51,548	30		9
10	Interest and Other Investment Income	(61,178)	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	(69,829)	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	(46,995)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (134,953)		$	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 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)	422,769		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 422,769		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 287,817		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

DeKalb County Rehab & Nursing

ID# 0044321

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing & Public Relations	$ (3,790)	43	1
2	Labs - Part A	(18,555)	43	2
3	X-Rays - Part A	(14,617)	43	3
4	Community Relations	(540)	43	4
5	Disallow Non-Allowable Legal	(6,546)	19	5
6	Disallow Yellow Page Advertising	(2,947)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(46,995)		49

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

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, Illinoi	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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Department chargeback	$ 154,000	DeKalb County, Illinois	100.00%	$ 154,000	$	1
2	V	22	FICA Taxes	477,952	DeKalb County, Illinois	100.00%	477,952		2
3	V	22	IMRF	608,727	DeKalb County, Illinois	100.00%	608,727		3
4	V	22	Health Insurance	1,046,225	DeKalb County, Illinois	100.00%	1,046,225		4
5	V	22	Workers Comp	141,015	DeKalb County, Illinois	100.00%	141,015		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			$ 2,427,919			$ 2,427,919	$ *	14

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

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

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	DeKalb County, Illinois	100.00%	$ 7,202	$ 7,202	15
16	V	7	Employee Benefit-Plan		DeKalb County, Illinois	100.00%	28,223	28,223	16
17	V	17	County Board Costs		DeKalb County, Illinois	100.00%	64,555	64,555	17
18	V	19	State's Attorney		DeKalb County, Illinois	100.00%	8,041	8,041	18
19	V	21	Departmental and non-departmental costs		DeKalb County, Illinois	100.00%	230,893	230,893	19
20	V	26	Risk Management		DeKalb County, Illinois	100.00%	21,595	21,595	20
21	V	27	Employee Benefit-G&A		DeKalb County, Illinois	100.00%	62,260	62,260	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			$			$ 422,769	$ * 422,769	39

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

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

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	OPERATING BOARD								$		1
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	Ken Anderson	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	5
6	Gary Hanson	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	6
7	Andrew Buffenbarger	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	7
8	Lynn Shepard	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	8
9	Brenda Bannon	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	9
10	Rita Nielsen	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	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 County Rehab & Nursing # 0044321 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 [X] NO [ ]

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

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

	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	*	*	*	$ 7,202	$		$ 7,202	1
2	7	Employee Benefits-Plant	*	*	*	28,223			28,223	2
3	17	County Board Costs	*	*	*	64,555			64,555	3
4	19	State's Attorney	*	*	*	8,041			8,041	4
5	21	Departmental and Non Departme	*	*	*	230,893			230,893	5
6	26	Risk Management	*	*	*	21,595			21,595	6
7	27	Employee Benefits-G&A	*	*	*	62,260			62,260	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					$ 422,769	$		$ 422,769	25

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

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bonds	X		Facility Construction	Varies	2005	$ 7,155,000	$ 2,986,638	2016	0.0520	$ 148,734	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 7,155,000	$ 2,986,638			$ 148,734	9
	B. Non-Facility Related*											
10								Interest Income Offset			(61,178)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (61,178)	14
15	TOTALS (line 9+line14)						$ 7,155,000	$ 2,986,638			$ 87,556	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.)**

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2011	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011	N/A	12

County Facility - exempt from real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DeKalb County Rehab & Nursing COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0044321

CONTACT PERSON REGARDING THIS REPORT Doreen Akers

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

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	County Facility - exempt from real estate taxes.		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	Resident Care	243,065	1998	$ 83,098	1
2					2
3	TOTALS	243,065		$ 83,098	3

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

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	$	$ 5,589,119	4
5			2000	2000	117,663	4,707	25	4,707		60,401	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		10,811	9
10	Construction Cap. Rpt cost - new building 3/9/00			2000	10,553	654	15 to 25	654		6,716	10
11	Cap. Rpt. Costs - new building since 3/9/00			2000	37,957	2,297	10 to 25	2,297		28,856	11
12	Maint. Building see fac. Letter and OHF rpt 6/18/01			2000	109,759	5,488	20	5,488		70,429	12
13	Electric,Acoustical duct repair,seal coat dry wall			2001	21,941	830	5 to 24	830		12,596	13
14	Half gate,workstation,swing door,gazebo, & concrete			2001	63,596	4,258	15 to 20	4,258		49,040	14
15	Duct repair,dumpster,slab,stainless steel-kitchen			2002	10,421	485	5 to 25	485		7,401	15
16	Employee entrance & courtyard landscaping			2003	11,355	1,135	10	1,135		10,678	16
17	Locks on doors, stainless steel walls dietary,lot lights			2004	30,177	2,804	6 to 15	2,804		24,584	17
18	Maint. Mezzanine, replace fire system, fire lane, compressor			2005	24,617	2,775	5 to 20	2,775		20,784	18
19	Architect,construction,painting,programming, dementia uni			2005	339,823	29,700	20	29,700		210,376	19
20	Mirror,painting,replace concrete CVS,replace 29 sprinklers			2006	9,978	969	5 to 18	969		6,309	20
21	Replace 2 doors, add magnets, install magnets & smoke detectors			2006	13,813	1,002	5	1,002		6,275	21
22	Painting in dining rooms			2007	7,840	820	5	820		7,840	22
23	Replace 600aMP Switch			2007	4,847	373	13	373		2,175	23
24	New Phone System			2007	22,000	2,200	10	2,200		11,367	24
25	New Phone System (Final)			2007	50,589	5,059	10	5,059		25,716	25
26	Steel Doors			2008	3,290	165	20	165		769	26
27	Fencing			2008	21,179	1,412	15	1,412		5,766	27
28	Magnetic Gate			2009	2,887	280	10	280		1,080	28
29	Upgrade controls			2009	7,904	790	10	790		3,029	29
30	Wood wrap on Front Columns			2009	6,940	463	15	463		1,697	30
31	Repair Dietary Floor			2009	7,800	390	20	390		1,430	31
32	New Door by laundry			2009	5,290	353	15	353		1,294	32
33	New Canopy in CVS			2009	3,063	204	15	204		731	33
34	New Concrete around building			2009	15,996	1,066	15	1,066		3,642	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 & Nursing # 0044321 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HD Swing Operator w/ control	2011	$ 2,841	$ 284	10	$ 284	$	$ 426	37
38	Replace Fire Eye Controller	2011	3,601	300	12	300		450	38
39									39
40	Exit Devices @ CVS Von Duprin	2012	3,651	183	10	183		183	40
41	Exit Devices @ Bldg A Von Duprin	2012	3,651	183	10	183		183	41
42	New Freezer Compressor	2012	5,271	264	10	264		264	42
43	Rebuilt series 80 pumps #1,#2, #3	2012	5,062	253	10	253		253	43
44	Resurfacing Parking Lot	2012	122,272	7,642	8	7,642		7,642	44
45	Gazebo Improvements - Foundation	2012	7,250	967	3.75	967		967	45
46									46
47									47
48									48
49									49
50	Reconcile to financial statement			(51,548)			51,548		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)		$ 12,015,063	$ 465,505		$ 517,053	$ 51,548	$ 6,191,280	70

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

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

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	$ 1,771,322	$ 97,231	$ 97,231	$	5-15	$ 1,547,272	71
72	Current Year Purchases	9,256	526	526		5-10	526	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,780,578	$ 97,757	$ 97,757	$		$ 1,547,798	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)	$ 13,901,122	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 563,262	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 614,810	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 51,548	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,761,461	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	Senior Living Facility	$ 3,332	92
93			93
94			94
95		$ 3,332	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 & Nursing # 0044321 Report Period Beginning: 01/01/12 Ending: 12/31/12

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. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

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

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 78,015 Description: Nursing Equipment $66,799; Maintenance $1,250; Copy & Postage Machines $9,966
    (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

* 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.

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

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
   [X] 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.

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	4,866	$ 307,709	$	4,866	$ 307,709	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,029	69,062		1,029	69,062	2
3	Licensed Recreational Therapist		hrs		5,627	366,155		5,627	366,155	3
4	Licensed Physical Therapist	39(3)	hrs							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 prescrpts				132,639		132,639	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			$	11,522	$ 742,926	$ 132,639	11,522	$ 875,565	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.

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,026,344	$ 1,026,344	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 354,829)	2,821,911	2,821,911	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	4,263,015	4,263,015	5
6	Prepaid Insurance	82,297	82,297	6
7	Other Prepaid Expenses	175,840	175,840	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)**	$ 8,373,399	$ 8,373,399	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	921,950	1,009,506	15
16	Equipment, at Historical Cost	1,734,879	1,802,961	16
17	Accumulated Depreciation (book methods)	(7,884,428)	(7,761,461)	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 (spe CIP: Courtyard Prog.	3,332	3,332	22
23	Other(specify): Reserve for IGT	388,660	388,660	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,424,019	$ 6,531,653	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,797,419	$ 14,905,053	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 690,815	$ 690,815	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	423,044	423,044	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	368,669	368,669	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	100,629	100,629	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interest Payable & Work Comp. Res.	473,537	473,537	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,056,694	$ 2,056,694	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,986,638	2,986,638	41
42	Deferred Compensation	402,519	402,519	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,389,157	$ 3,389,157	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,445,851	$ 5,445,851	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,351,568	$ 9,459,202	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,797,419	$ 14,905,053	48

*(See instructions.)

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,808,010	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(545,299)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,262,711	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	88,857	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)**	$ 88,857	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)**	$ 10,351,568	24 *

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

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

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,341,808	1
2	Discounts and Allowances for all Levels	(6,075,462)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,266,346	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,492,603	6
7	Oxygen	182,925	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,675,528	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	159,900	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,499	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	427,340	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,977	19
20	Radiology and X-Ray	15,633	20
21	Other Medical Services	690,243	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,323,592	23
	D. Non-Operating Revenue		
24	Contributions	58,418	24
25	Interest and Other Investment Income***	61,178	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 119,596	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Sch 19A	925,808	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 925,808	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,310,870	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,373,601	31
32	Health Care	6,126,069	32
33	General Administration	3,274,069	33
	B. Capital Expense		
34	Ownership	790,011	34
	C. Ancillary Expense		
35	Special Cost Centers	984,199	35
36	Provider Participation Fee	674,064	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,222,014	40
41	**Income before Income Taxes (line 30 minus line 40)****	88,857	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 88,857	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,726,141	44
45	Private Pay - Net Inpatient Revenue	2,947,272	45
46	Medicare - Net Inpatient Revenue	1,592,933	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,266,346	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

28a.

Revenue	Amount
M/C Cost Report Settlement	16,649
Medicaid County Portion	746,337
Maintenance	-
Miscellaneous	163,684
Loss on Disposal of FA	(862)
Total Other Revenue	925,808

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,829	2,115	$ 84,214	$ 39.82	1
2	Assistant Director of Nursing	1,852	2,015	63,068	31.30	2
3	Registered Nurses	42,497	47,052	1,398,357	29.72	3
4	Licensed Practical Nurses	12,357	17,175	292,355	17.02	4
5	CNAs & Orderlies	136,605	148,688	2,031,121	13.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,221	10,572	182,549	17.27	8
9	Activity Director	1,837	2,140	42,238	19.74	9
10	Activity Assistants	9,312	10,079	98,565	9.78	10
11	Social Service Workers	7,484	8,464	166,939	19.72	11
12	Dietician	1,883	2,140	51,807	24.21	12
13	Food Service Supervisor	2,599	3,048	55,177	18.10	13
14	Head Cook	1,711	2,272	29,391	12.94	14
15	Cook Helpers/Assistants	6,273	7,066	74,598	10.56	15
16	Dishwashers	38,794	42,297	394,319	9.32	16
17	Maintenance Workers	5,200	5,823	117,300	20.14	17
18	Housekeepers	20,485	23,550	236,752	10.05	18
19	Laundry	6,574	7,236	70,355	9.72	19
20	Administrator	2,080	2,080	83,169	39.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,534	13,733	175,591	12.79	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	31,788	35,587	833,093	23.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	352,915	393,132	$ 6,480,958 *	$ 16.49	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	578	$ 28,382	1(3)	35
36	Medical Director	317	35,413	9(3)	36
37	Medical Records Consultant	422	8,430	10(3)	37
38	Nurse Consultant	Monthly	3,600	10(3)	38
39	Pharmacist Consultant	Flat fess	12,280	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	24	1,848	11(3)	44
45	Social Service Consultant	8	658	12(3)	45
46	Other(specify)				46
47					47
48	Other - See Sch 20B		9,575	10(3)	48
49	TOTAL (lines 35 - 48)	1,349	$ 100,186		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,242	$ 52,090	10(3)	50
51	Licensed Practical Nurses	3,462	130,582	10(3)	51
52	Certified Nurse Assistants/Aides	14,098	295,861	10(3)	52
53	TOTAL (lines 50 - 52)	18,802	$ 478,533		53

DeKalb County Rehab & Nursing Center
Provider #: 0044321
01/01/12- 12/31/12 **Schedule 20A**

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

Description	Hours Worked	Hours Paid	Salary	Ave. Hrly. Wage
Care Plan Coordinator	1,975	2,094	65,180	31.13
House Supervisor	3,395	4,185	######	38.98
Scheduling Coord	1,909	2,199	40,959	18.63
Clinical & Support Services Coordinator	1,920	2,130	78,127	36.68
CVS Department Head	1,783	2,015	69,122	34.30
Unit Clerk and Assistant	9,765	10,350	######	10.88
Medicare Case Manager	4,521	5,013	######	31.38
Nursing Secretary	2,384	2,790	55,635	19.94
Ward Secretary	4,136	4,811	90,962	18.91
	31,788	35,587	######	23.41

DeKalb County Rehab & Nursing Center **SCH 20B**

Provider #: 0044321

01/01/12- 12/31/12

	1	2	3
	Number of Hrs. Paid & Accrued	Cost for Reporting Period	Schedule V Line & Column Reference
Others			
Nursing dental consultant	Flat Fee	900	10(3)
Nursing utilization review	Monthly	8,675	10(3)
Total		**9,575**	

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine Anderson	Administrator	0	$ 83,169
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,169

B. Administrative - Other

Description	Amount
Management Performance Association	$ 165,673
TOTAL (agree to Schedule V, line 17, col. 3)	$ 165,673
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
McGladrey	Accounting	$ 12,580
Laner Muchin Dombrow Becker Lev	Legal	8,448
Polsinelli Shughart PC	Legal	4,504
Myers Carden & Sax LLC	Legal	21,394
Stricklin & Associates	Legal	8,167
Pinnacle Consulting	Accounting	1,400
Management Performance Associati	Accounting	40,140
Provinet Solutions	Computer Services	58,549
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 155,182

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 141,015
Unemployment Compensation Insurance	24,080
FICA Taxes	477,952
Employee Health Insurance	1,046,226
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	608,727
Tort & Liability Fund (Work Comp)	15,424
Work Comp Salaries	28,855
Uniform Allowance	22,884
Employee Medical Expense	4,621
Employee Life Insurance	25,382
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,395,166

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	24,118
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 360	4,316
Life Services Network of Illinois dues	6,817
Vision Share	
Miscellaneous Dues & Subscriptions	7,170
HealthCare Information Subscription	
AAHSA Dues	450
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(2,947)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,924

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,304
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,304

* Attach copy of IMRF notifications

**See instructions.

DeKalb County Rehab & Nursing Center
Provider #: 0044321
01/01/12 - 12/31/12 **Schedule 21C**

XIX. SUPPORT SERVICES - Section C Professional Services

Per Schedule V, Line 19, Column 3		155,182
Add:	Indirect County Allocation	8,041
Less:	Non-allowable legal retain	(6,546)
To Schedule V, Line 19, Column 8		**156,677**

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

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		$		$	$	$	$	$	$	$	$	$

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

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 - $6,817**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **75,108** 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. $ **674,064**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,499**

(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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.