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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0044321

Facility Name: DeKalb County Rehab & Nrsing

Address: 2600 N Annie Glidden (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 01/01/2015 to 12/31/2015 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) RSM US 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 & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	69,350	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,077	276	9,568	10,921	8
9	SNF/PED					9
10	ICF	35,342	15,391		50,733	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,419	15,667	9,568	61,654	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.90%

D. How many bed-hold days during this year were paid by the Department?
N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [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 9,568

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	600,025	41,264	29,141	670,430		670,430		670,430			1
2	Food Purchase		388,745		388,745		388,745	(2,942)	385,803			2
3	Housekeeping	207,502	54,894	201,986	464,382		464,382		464,382			3
4	Laundry	71,045	13,865		84,910		84,910		84,910			4
5	Heat and Other Utilities			298,583	298,583		298,583	(1,333)	297,250			5
6	Maintenance	116,068	77,794	135,863	329,725		329,725	6,862	336,587			6
7	Other (specify):*											7
8	TOTAL General Services	994,640	576,562	665,573	2,236,774		2,236,774	2,587	2,239,361			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	4,481,726	279,799	877,888	5,639,413		5,639,413		5,639,413			10
10a	Therapy	196,232			196,232		196,232		196,232			10a
11	Activities	129,542	5,530	17,050	152,122		152,122		152,122			11
12	Social Services	174,341		613	174,954		174,954		174,954			12
13	CNA Training											13
14	Program Transportation			2,648	2,648		2,648		2,648			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,981,841	285,329	904,199	6,171,369		6,171,369		6,171,369			16
	C. General Administration											
17	Administrative	115,289		159,178	274,467		274,467	61,512	335,979			17
18	Directors Fees											18
19	Professional Services			260,692	260,692		260,692	(14,489)	246,203			19
20	Dues, Fees, Subscriptions & Promotions			57,303	57,303		57,303	(8,431)	48,872			20
21	Clerical & General Office Expenses	203,600	39,541	204,577	447,718		447,718	215,928	663,646			21
22	Employee Benefits & Payroll Taxes			2,564,017	2,564,017		2,564,017	86,218	2,650,235			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,026	4,026		4,026		4,026			24
25	Other Admin. Staff Transportation			1,624	1,624		1,624		1,624			25
26	Insurance-Prop.Liab.Malpractice			146,848	146,848		146,848	20,576	167,424			26
27	Other (specify):*											27
28	TOTAL General Administration	318,889	39,541	3,398,265	3,756,695		3,756,695	361,314	4,118,009			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,295,370	901,432	4,968,037	12,164,838		12,164,838	363,901	12,528,739			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 & Nrsing #0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			606,543	606,543		606,543	(10,571)	595,972			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,572	72,572		72,572	(55,407)	17,165			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			38,286	38,286		38,286		38,286			35
36	Other (specify):*											36
37	**TOTAL Ownership**			717,401	717,401		717,401	(65,978)	651,423			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			5,024	5,024		5,024		5,024			38
39	Ancillary Service Centers		278,420	863,131	1,141,551		1,141,551	(19,056)	1,122,495			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			420,187	420,187		420,187		420,187			42
43	Other (specify):* Non-Allowable Cos			77,868	77,868		77,868	(77,868)				43
44	**TOTAL Special Cost Centers**		278,420	1,366,210	1,644,630		1,644,630	(96,924)	1,547,706			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,295,370	1,179,852	7,051,648	14,526,869		14,526,869	200,999	14,727,868			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 & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	(2,942)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,846)	30		9
10	Interest and Other Investment Income	(55,407)	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	(48,264)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(87,384)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (201,843)		$	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)	402,842		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 402,842		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 200,999		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

DeKalb County Rehab & Nrsing

ID# 0044321

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing & Public Relations	$ (920)	43	1
2	Labs - Part A	(16,969)	43	2
3	X-Rays - Part A	(10,612)	43	3
4	Community Relations	(419)	43	4
5	Disallow Non-Allowable Legal	(22,153)	19	5
6	Disallow Non-Allowable Advertising	(3,687)	20	6
7	Loss on Disposal	(684)	43	7
8	Lobbying Offset	(4,744)	20	8
9	Offset Misc. Income	(4,082)	21	9
10	Disallow Outpatient Therapy - Ancillary	(19,056)	39	10
11	Disallow Outpatient Therapy - Depreciation	(2,725)	30	11
12	Disallow Outpatient Therapy - Maintenance	(1,333)	5	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**	(87,384)		49

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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, IL	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	$ 164,000	DeKalb County, Illinois	100.00%	$ 164,000	$	1
2	V	22	FICA Taxes	471,735	DeKalb County, Illinois	100.00%	471,735		2
3	V	22	IMRF	679,129	DeKalb County, Illinois	100.00%	679,129		3
4	V	22	Health Insurance	1,132,481	DeKalb County, Illinois	100.00%	1,132,481		4
5	V	22	Workers Comp	(15,797)	DeKalb County, Illinois	100.00%	(15,797)		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			$ 2,431,548			$ 2,431,548	$ * 0	14

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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%	$ 6,862	$ 6,862	15
16	V	22	Employee Benefit-Plan		DeKalb County, Illinois	100.00%	23,039	23,039	16
17	V	17	County Board Costs		DeKalb County, Illinois	100.00%	61,512	61,512	17
18	V	19	State's Attorney		DeKalb County, Illinois	100.00%	7,664	7,664	18
19	V	21	Departmental and non-departmental costs		DeKalb County, Illinois	100.00%	220,010	220,010	19
20	V	26	Risk Management		DeKalb County, Illinois	100.00%	20,576	20,576	20
21	V	22	Employee Benefit-G&A		DeKalb County, Illinois	100.00%	63,179	63,179	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 402,842	$ * 402,842	39

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	Rita Nielsen	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	5
6	Jeff Whelan	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	6
7	Misty Haji-Sheikh	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	7
8	Greg Millburg	Member	Administrative	0.00	NONE	1	2.00	N/A		N/A	8
9											9
10	No members of the operating board provide services to the county.										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 & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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	*	*	*	$ 6,862	$		$ 6,862	1
2	22	Employee Benefits-Plan	*	*	*	23,039			23,039	2
3	17	County Board Costs	*	*	*	61,512			61,512	3
4	19	State's Attorney	*	*	*	7,664			7,664	4
5	21	Departmental and Non Departme	*	*	*	220,010			220,010	5
6	26	Risk Management	*	*	*	20,576			20,576	6
7	22	Employee Benefits-G&A	*	*	*	63,179			63,179	7
8										8
9										9
10		See Schedule 8A for Method of Allocation								10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 402,842	$		$ 402,842	25

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 1,066,638	2016	0.0520	$ 72,572	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 7,155,000	$ 1,066,638			$ 72,572	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(55,407)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (55,407)	14
15	TOTALS (line 9+line14)						$ 7,155,000	$ 1,066,638			$ 17,165	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 & Nrsing **#** 0044321 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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.)	**2014**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2015 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.)**	**Allocated from Managment Co.**	$	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:			
	2010		**8**
	2011		**9**
	2012	**N/A**	**10**
	2013		**11**
	2014		**12**

County Facility - exempt from real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	**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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DeKalb County Rehab & Nursing Center 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 2014 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 2014.

	(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 _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$	$ 6,895,667	4
5			2000	2000	117,663	4,707	25	4,707		74,522	5
6											6
7											7
8											8
	Improvement Type**										
9	Construction Cap. Rpt cost - new building 3/9/00			1999	12,293		10 to 20			12,293	9
10	Construction Cap. Rpt cost - new building 3/9/00			2000	10,553	654	15 to 25	654		8,678	10
11	Cap. Rpt. Costs - new building since 3/9/00			2000	37,957	2,297	10 to 25	2,297		35,746	11
12	Maint. Building see fac. Letter and OHF rpt 6/18/01			2000	109,759	5,488	20	5,488		86,893	12
13	Electric,Acoustical duct repair,seal coat dry wall			2001	21,941	830	5 to 24	830		15,085	13
14	Half gate,workstation,swing door,gazebo, & concrete			2001	63,596	4,258	15 to 20	4,258		61,815	14
15	Duct repair,dumpster,slab,stainless steel-kitchen			2002	10,421	485	5 to 25	485		8,856	15
16	Employee entrance & courtyard landscaping			2003	11,355		10			11,355	16
17	Locks on doors, stainless steel walls dietary,lot lights			2004	30,177		6 to 15			30,177	17
18	Maint. Mezzanine, replace fire system, fire lane, compressor			2005	24,617		5 to 20			24,617	18
19	Architect,construction,painting,programming, dementia uni			2005	339,823	29,700	20	29,700		299,477	19
20	Mirror,painting,replace concrete CVS,replace 29 sprinklers			2006	9,978	969	5 to 18	969		9,216	20
21	Replace 2 doors, add magnets, install magnets & smoke detectors			2006	13,813	1,002	5	1,002		9,282	21
22	Painting in dining rooms			2007	7,840		5			7,840	22
23	Replace 600aMP Switch			2007	4,847	373	13	373		3,294	23
24	New Phone System			2007	22,000	2,200	10	2,200		17,966	24
25	New Phone System (Final)			2007	50,589	5,059	10	5,059		40,893	25
26	Steel Doors			2008	3,290	165	20	165		1,262	26
27	Fencing			2008	21,179	1,412	15	1,412		10,002	27
28	Magnetic Gate			2009	2,887	280	10	280		1,919	28
29	Upgrade controls			2009	7,904	790	10	790		5,400	29
30	Wood wrap on Front Columns			2009	6,940	463	15	463		3,085	30
31	Repair Dietary Floor			2009	7,800	390	20	390		2,600	31
32	New Door by laundry			2009	5,290	353	15	353		2,352	32
33	New Canopy in CVS			2009	3,063	204	15	204		1,344	33
34	New Concrete around building			2009	15,996	1,066	15	1,066		6,840	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$	$ 1,278	37
38	Replace Fire Eye Controller	2011	3,601	300	12	300		1,350	38
39									39
40	Exit Devices @ CVS Von Duprin	2012	3,651	183	10	183		732	40
41	Exit Devices @ Bldg A Von Duprin	2012	3,651	183	10	183		732	41
42	New Freezer Compressor	2012	5,271	264	10	264		1,056	42
43	Rebuilt series 80 pumps #1,#2, #3	2012	5,062	253	10	253		1,012	43
44	Resurfacing Parking Lot	2012	122,272	7,642	8	7,642		30,568	44
45	Gazebo Improvements - Foundation	2012	7,250	967	3.75	967		3,868	45
46									46
47	14x24 Garage Wood-donation	2013	5,870	391	15	391		881	47
48	Replae Module in Fireye Boiler	2013	5,844	584	10	584		1,656	48
49	Rebuild Hot Water Pump in Service	2013	3,755	376	10	376		1,064	49
50	Replace HW Valve on Air Handler	2013	3,661	366	10	366		1,037	50
51	Insulation Work On Trane 300 Ton	2013	3,201	213	15	213		533	51
52	Repair Lochinar Boilers	2013	5,153	429	12	429		1,038	52
53	Replace Parts for 300 Ton Chillers	2013	3,865	258	15	258		601	53
54	Replace Pontentiometer and Switch	2013	4,328	361	12	361		751	54
55	Remodel Admin office for 2 persons	2013	4,500	450	10	450		938	55
56	Hot water Pump #2 Bearing assembly	2013	4,791	479	10	479		1,038	56
57									57
58	Completion of Potenitiometer & Switch in Boiler	2014	3,360	336	10	336		680	58
59	Repair to sprinkler system	2014	3,837	320	12	320		639	59
60	Replace Expansion Valves on Chiller	2014	4,488	299	15	299		524	60
61	Replace boiler #1	2014	4,631	463	10	463		810	61
62	Generator control panel & primer pump	2014	15,502	1,292	12	1,292		2,153	62
63	Replace condenser Fan motor on chiller	2014	4,264	284	15	284		474	63
64	Freezer door in kitchen	2014	4,717	629	7.5	629		733	64
65									65
66	New concrete sidewalk	2015	3,500	175	15	175		175	66
67	Replace Fusible Switch in Main	2015	2,503	188	10	188		188	67
68	Rebuild Chilled Water Pump #1	2015	6,136	460	10	460		460	68
69	Replace 3 motors due to short	2015	3,189	239	10	239		239	69
70	TOTAL (lines 4 thru 69)		$ 12,116,158	$ 517,329		$ 517,329	$	$ 7,745,685	70

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	
1	Totals from Page 12A, Carried Forward		$ 12,116,158	$ 517,329		$ 517,329	$	$ 7,745,685	1
2	Replaced Bolted pressure switch	2015	12,922	574	15	574		574	2
3	Hot water lines building A&B	2015	5,437	323	9.8	323		323	3
4	Replace Oil Pressure Switches	2015	3,936	109	15	109		109	4
5									5
6									6
7									7
8	Adjustment to Financial Statements			10,571			(10,571)		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	TOTAL (lines 1 thru 33)		$ 12,138,453	$ 528,906		$ 518,335	$ (10,571)	$ 7,746,691	34

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 1,849,238	$ 68,713	$ 68,713	$	5-20	$ 1,784,573	71
72	Current Year Purchases	61,098	2,879	2,879		5-20	2,879	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,910,336	$ 71,592	$ 71,592	$		$ 1,787,452	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	Maintenance	2015 GMC Sierra w/plow	2015	32,974	6,045	6,045		5	6,045	77
78										78
79										79
80	TOTALS			$ 55,357	$ 6,045	$ 6,045	$		$ 28,428	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,187,244	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 606,543	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 595,972	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,571)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,562,571	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 38,286 Description: Nursing Equipment $27,249, Maintenance $1,278, Copy & Postage Machine $9,759
    (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 & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	39(3)	hrs	$	6,020	$ 302,091	$	6,020	$ 302,091	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,167	92,348		2,167	92,348	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		4,805	358,556		4,805	358,556	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				253,539		253,539	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapist	39(3)			1,637	91,080		1,637	91,080	12
13	Other (specify): Oxygen						24,881		24,881	13
14	TOTAL			$	14,629	$ 844,075	$ 278,420	14,629	$ 1,122,495	14

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 873,806	$ 873,806	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (866,816))	2,133,560	2,133,560	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	3,776,355	3,776,355	5
6	Prepaid Insurance	88,851	88,851	6
7	Other Prepaid Expenses	166,328	166,328	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)**	$ 7,042,892	$ 7,042,892	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,098	83,098	13
14	Buildings, at Historical Cost	12,182,398	11,005,557	14
15	Leasehold Improvements, at Historical Cost	1,050,833	1,132,896	15
16	Equipment, at Historical Cost	1,768,775	1,965,693	16
17	Accumulated Depreciation (book methods)	(9,499,518)	(9,562,571)	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			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,585,586	$ 4,624,673	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,628,478	$ 11,667,565	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 653,126	$ 653,126	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,643	115,643	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	76,565	76,565	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interest Payable & Work Comp. Res.	405,781	405,781	36
37	Due to Retirement Fund	270,679	270,679	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,521,795	$ 1,521,795	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,066,638	1,066,638	41
42	Deferred Compensation	306,264	306,264	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,372,902	$ 1,372,902	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,894,696	$ 2,894,696	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,733,782	$ 8,772,869	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,628,478	$ 11,667,565	48

*(See instructions.)

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,521,242	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	(862,326)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,658,916	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	74,866	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)**	$ 74,866	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)**	$ 9,733,782	24	*

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 12,800,962	1
2	Discounts and Allowances for all Levels	(3,532,267)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,268,695	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,811,420	6
7	Oxygen	152,042	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,963,462	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	142,459	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,942	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	290,353	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,642	19
20	Radiology and X-Ray	13,610	20
21	Other Medical Services	827,212	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,296,218	23
	D. Non-Operating Revenue		
24	Contributions	69,155	24
25	Interest and Other Investment Income***	55,407	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 124,562	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Sch 19A	948,798	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 948,798	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,601,735	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,236,774	31
32	Health Care	6,171,369	32
33	General Administration	3,756,695	33
	B. Capital Expense		
34	Ownership	717,401	34
	C. Ancillary Expense		
35	Special Cost Centers	1,224,443	35
36	Provider Participation Fee	420,187	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,526,869	40
41	**Income before Income Taxes (line 30 minus line 40)****	74,866	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 74,866	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,671,660	44
45	Private Pay - Net Inpatient Revenue	3,088,157	45
46	Medicare - Net Inpatient Revenue	1,508,878	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,268,695	49

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

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

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

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

^ -County Home - No Tax Return Filed

Facility Name: **DeKalb County Rehab & Nrsing**
IDPH License ID Number: **0044321**
Fiscal Year End: **12/31/2015**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
M/C Cost Report Settlement	23,069
Medicaid County Portion	821,635
SLF Donations	100,000
Uniform Revenue	12
Miscellaneous	4,052
Total - Line 28	**948,768**

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	1,892	2,310	$ 102,714	$ 44.46	1
2	Assistant Director of Nursing	716	800	30,631	38.29	2
3	Registered Nurses	41,326	47,958	1,386,437	28.91	3
4	Licensed Practical Nurses	13,985	15,747	371,289	23.58	4
5	CNAs & Orderlies	132,460	144,064	1,696,554	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,689	11,333	196,232	17.32	8
9	Activity Director	1,899	2,175	41,984	19.30	9
10	Activity Assistants	8,604	9,880	87,558	8.86	10
11	Social Service Workers	7,650	8,774	174,341	19.87	11
12	Dietician	2,383	2,702	49,769	18.42	12
13	Food Service Supervisor	1,883	2,218	55,967	25.23	13
14	Head Cook	1,746	2,012	26,647	13.24	14
15	Cook Helpers/Assistants	6,793	7,694	83,702	10.88	15
16	Dishwashers	40,384	43,331	383,940	8.86	16
17	Maintenance Workers	5,207	5,782	116,068	20.07	17
18	Housekeepers	19,756	21,383	207,502	9.70	18
19	Laundry	6,029	7,072	71,045	10.05	19
20	Administrator	2,304	2,304	115,289	50.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,998	15,649	203,600	13.01	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 CSee Sch 20A	33,146	37,558	894,101	23.81	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	351,850	390,746	$ 6,295,370 *	$ 16.11	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	569	$ 29,141	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	571	18,613	10(3)	37
38	Nurse Consultant	Monthly	1,722	10(3)	38
39	Pharmacist Consultant	Flat Fee	16,688	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	34	1,722	11(3)	44
45	Social Service Consultant	8	613	12(3)	45
46	Other(specify)				46
47	Nursing Dental	Flat Fee	900	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	1,182	$ 75,399		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,985	$ 90,234	10(3)	50
51	Licensed Practical Nurses	5,251	214,166	10(3)	51
52	Certified Nurse Assistants/Aides	25,177	535,565	10(3)	52
53	TOTAL (lines 50 - 52)	32,413	$ 839,965		53

Facility Name: **DeKalb County Rehab & Nrsing**
IDPH License ID Number: **0044321**
Fiscal Year End: **12/31/2015**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Inservice Instructor	1,231	1,281	37,976	$ 29.65
Care Plan Coordinator	2,077	2,265	74,389	$ 32.84
House Supervisor	4,160	4,862	186,637	$ 38.39
Scheduling Coordinator	2,015	2,354	45,004	$ 19.12
Clinical Support Services Coordinator	1,229	1,320	33,056	$ 25.04
CVS Department Head	1,930	2,323	73,224	$ 31.52
Unit Clerk and Assistant	8,851	9,779	105,370	$ 10.78
Medicare Case Manager	4,911	5,765	187,342	$ 32.50
Nursing Secretary	2,494	2,752	55,672	$ 20.23
Ward Secretary	4,248	4,857	95,431	$ 19.65
Total - Line 32 Other Health Care (specify):	**33,146**	**37,558**	**894,101**	**$ 23.81**

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine Anderson	Administrator	0	$ 86,930
Bart Becker	Administrator	0	28,359
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,289

B. Administrative - Other

Description	Amount
Management Performance Associates	$ 159,178
TOTAL (agree to Schedule V, line 17, col. 3)	$ 159,178
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21C		$ 260,692
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 260,692

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ (15,797)
Unemployment Compensation Insurance	23,957
FICA Taxes	471,735
Employee Health Insurance	1,132,481
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	814,469
Tort & Liability Fund (Work Comp)	7,526
Work Comp Salaries	82,179
Uniform Allowance	22,485
Employee Medical Expense	4,591
Employee Life Insurance	11,723
Allocated FICA/IMRF	86,218
Health Savings Account	8,668
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,650,235

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	38,314
Health Care Worker Background Check	
(Indicate # of checks performed 51)	1,785
Patient Background Checks 214	2,175
Life Services Network of Illinois dues	8,646
Less Lobbying Dues	(4,744)
Miscellaneous Dues & Subscriptions	1,852
HealthCare Information Subscription	
Leading Age	4,530
Less: Public Relations Expense	( )
Non-allowable advertising	(3,686)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,872

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,026
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,026

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **DeKalb County Rehab & Nrsing**
IDPH License ID Number: **0044321**
Fiscal Year End: **12/31/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	18,990
Laner Muchin Dombrow	Legal	6,000
Polsinelli Shughart PC	Legal	27,105
Myers Carden & Sax LLC	Legal	64,012
Stricklin & Associates	Legal	8,000
Foster & Buick	Legal	24,302
Pinnacle Consulting	Operation Consultant	4,125
Management Performance Association	Operation Consultant	41,903
Management Performance Association	Operation Consultant	41,250
Management Performance Association	Operation Consultant	14,648
Helen Turner	CPR Instructor	3,920
David Kuo, D.O. FACP	Expert Physician Witness Consultant	3,238
Diane Brown	Expert Nursing Wellness Consultant	3,200
	Total (agree to Schedule V, line 19, column 3)	260,692
Allocated from Management company	Professional Services	7,664
Less: Non-Allowable Legal Fees		(22,153)
	Total (agree to Schedule V, line 19, column 8)	246,203

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 & Nrsing # 0044321 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 & Leading Age - $13,176**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **69,368** 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. $ **420,187**
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. $ **2,942**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Sikich, Gardner & Co.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.