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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 01/01/2016 to 12/31/2016 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: 01/01/2016 Ending: 12/31/2016

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	915	216	9,268	10,399	8
9	SNF/PED					9
10	ICF	32,458	17,732	3,791	53,981	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,373	17,948	13,059	64,380	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.58%

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 7,458

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	587,377	40,502	29,590	657,469		657,469		657,469			1
2	Food Purchase		409,792		409,792		409,792	(1,990)	407,802			2
3	Housekeeping	230,179	57,435	239,782	527,396		527,396		527,396			3
4	Laundry	66,900	11,522		78,422		78,422		78,422			4
5	Heat and Other Utilities			288,623	288,623		288,623	(801)	287,822			5
6	Maintenance	123,209	70,093	134,500	327,802		327,802	6,951	334,753			6
7	Other (specify):*											7
8	TOTAL General Services	1,007,665	589,344	692,495	2,289,504		2,289,504	4,160	2,293,664			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	4,540,231	260,141	809,720	5,610,092		5,610,092		5,610,092			10
10a	Therapy	193,146			193,146		193,146		193,146			10a
11	Activities	120,289	7,208	19,209	146,706		146,706		146,706			11
12	Social Services	172,685		658	173,343		173,343		173,343			12
13	CNA Training											13
14	Program Transportation			2,172	2,172		2,172		2,172			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,026,351	267,349	837,759	6,131,459		6,131,459		6,131,459			16
	C. General Administration											
17	Administrative	104,672		159,509	264,181		264,181	62,312	326,493			17
18	Directors Fees											18
19	Professional Services			214,815	214,815		214,815	(10,143)	204,672			19
20	Dues, Fees, Subscriptions & Promotions			76,794	76,794		76,794	(6,972)	69,822			20
21	Clerical & General Office Expenses	212,178	46,127	180,789	439,094		439,094	215,855	654,949			21
22	Employee Benefits & Payroll Taxes			2,575,974	2,575,974		2,575,974	(12,386)	2,563,588			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,780	3,780		3,780		3,780			24
25	Other Admin. Staff Transportation			1,452	1,452		1,452		1,452			25
26	Insurance-Prop.Liab.Malpractice			46,523	46,523		46,523	20,844	67,367			26
27	Other (specify):*											27
28	TOTAL General Administration	316,850	46,127	3,259,636	3,622,613		3,622,613	269,510	3,892,123			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,350,866	902,820	4,789,890	12,043,576		12,043,576	273,670	12,317,246			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: 01/01/2016 Ending: 12/31/2016

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			592,981	592,981		592,981	4,144	597,125			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,215	44,215		44,215	(44,215)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			46,441	46,441		46,441		46,441			35
36	Other (specify):*											36
37	TOTAL Ownership			683,637	683,637		683,637	(40,071)	643,566			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			602	602		602		602			38
39	Ancillary Service Centers		267,489	884,200	1,151,689		1,151,689	(12,207)	1,139,482			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			438,578	438,578		438,578		438,578			42
43	Other (specify):* Non-Allowable Cos			102,338	102,338		102,338	(102,338)				43
44	TOTAL Special Cost Centers		267,489	1,425,718	1,693,207		1,693,207	(114,545)	1,578,662			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,350,866	1,170,309	6,899,245	14,420,420		14,420,420	119,054	14,539,474			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: 01/01/2016 Ending: 12/31/2016

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	(1,990)	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	5,795	30		9
10	Interest and Other Investment Income	(44,215)	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	(70,985)	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	(177,630)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (289,025)		$	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)	408,079		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 408,079		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 119,054		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 & Nrsing

ID# 0044321

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing & Public Relations	$ (1,226)	43	1
2	Labs - Part A	(18,179)	43	2
3	X-Rays - Part A	(7,546)	43	3
4	Community Relations	(2,229)	43	4
5	Disallow Non-Allowable Legal	(17,906)	19	5
6	Disallow Non-Allowable Advertising	(4,210)	20	6
7	Loss on Disposal	(2,173)	43	7
8	Lobbying Offset	(2,762)	20	8
9	Offset Misc. Income	(7,015)	21	9
10	Disallow Outpatient Therapy - Ancillary	(12,207)	39	10
11	Disallow Outpatient Therapy - Depreciation	(1,651)	30	11
12	Disallow Outpatient Therapy - Maintenance	(801)	5	12
13	IMRF Refund for Prior Year Expense	(99,725)	22	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**	(177,630)		49

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 152,000	DeKalb County, Illinois	1	$ 152,000	$	1
2	V	22	FICA Taxes	475,515	DeKalb County, Illinois	1	475,515		2
3	V	22	IMRF	709,358	DeKalb County, Illinois	1	709,358		3
4	V	22	Health Insurance	1,243,203	DeKalb County, Illinois	1	1,243,203		4
5	V	22	Workers Comp	68,382	DeKalb County, Illinois	1	68,382		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			$ 2,648,458			$ 2,648,458	$ * 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: 01/01/2016 Ending: 12/31/2016

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%	$ 6,951	$ 6,951	15
16	V	22	Employee Benefit-Plan		DeKalb County, Illinois	100.00%	24,453	24,453	16
17	V	17	County Board Costs		DeKalb County, Illinois	100.00%	62,312	62,312	17
18	V	19	State's Attorney		DeKalb County, Illinois	100.00%	7,763	7,763	18
19	V	21	Departmental and non-departmental costs		DeKalb County, Illinois	100.00%	222,870	222,870	19
20	V	26	Risk Management		DeKalb County, Illinois	100.00%	20,844	20,844	20
21	V	22	Employee Benefit-G&A		DeKalb County, Illinois	100.00%	62,886	62,886	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			$			$ 408,079	$ * 408,079	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: 01/01/2016 Ending: 12/31/2016

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	Greg Millburg	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											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: 01/01/2016 Ending: 2/31/2016

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	*	*	*	$ 6,951	$		$ 6,951	1
2	22	Employee Benefits-Plan	*	*	*	24,453			24,453	2
3	17	County Board Costs	*	*	*	62,312			62,312	3
4	19	State's Attorney	*	*	*	7,763			7,763	4
5	21	Departmental and Non Departmer	*	*	*	222,870			222,870	5
6	26	Risk Management	*	*	*	20,844			20,844	6
7	22	Employee Benefits-G&A	*	*	*	62,886			62,886	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					$ 408,079	$		$ 408,079	25

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 0	2016	0.0520	$ 44,215	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 7,155,000	$			$ 44,215	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(44,215)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (44,215)	14
15	TOTALS (line 9+line14)						$ 7,155,000	$			$	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: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	2015	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 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:		
2011		8
2012	N/A	9
2013		10
2014		11
2015		12

County Facility - exempt from real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 Janet George

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 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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	$	$ 7,331,183	4
5			2000	2000	117,663	4,707	25	4,707		79,229	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		9,332	10
11	Cap. Rpt. Costs - new building since 3/9/00			2000	37,957	2,211	10 to 25	2,211		37,957	11
12	Maint. Building see fac. Letter and OHF rpt 6/18/01			2000	109,759	5,488	20	5,488		92,381	12
13	Electric,Acoustical duct repair,seal coat dry wall			2001	21,941	830	5 to 24	830		15,915	13
14	Half gate,workstation,swing door,gazebo, & concrete			2001	63,596	1,781	15 to 20	1,781		63,596	14
15	Duct repair,dumpster,slab,stainless steel-kitchen			2002	10,421	485	5 to 25	485		9,341	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		329,177	19
20	Mirror,painting,replace concrete CVS,replace 29 sprinklers			2006	9,978	762	5 to 18	762		9,978	20
21	Replace 2 doors, add magnets, install magnets & smoke detectors			2006	13,813	1,002	5	1,002		10,284	21
22	Painting in dining rooms			2007	7,840		5			7,840	22
23	Replace 600aMP Switch			2007	4,847	373	13	373		3,667	23
24	New Phone System			2007	22,000	2,200	10	2,200		20,166	24
25	New Phone System (Final)			2007	50,589	5,059	10	5,059		45,952	25
26	Steel Doors			2008	3,290	165	20	165		1,427	26
27	Fencing			2008	21,179	1,412	15	1,412		11,414	27
28	Magnetic Gate			2009	2,887	280	10	280		2,199	28
29	Upgrade controls			2009	7,904	790	10	790		6,190	29
30	Wood wrap on Front Columns			2009	6,940	463	15	463		3,548	30
31	Repair Dietary Floor			2009	7,800	390	20	390		2,990	31
32	New Door by laundry			2009	5,290	353	15	353		2,705	32
33	New Canopy in CVS			2009	3,063	204	15	204		1,548	33
34	New Concrete around building			2009	15,996	1,066	15	1,066		7,906	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: 01/01/2016 Ending: 12/31/2016

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	$	$ 1,562	37
38	Replace Fire Eye Controller	2011	3,601	300	12	300		1,650	38
39									39
40	Exit Devices @ CVS Von Duprin	2012	3,651	183	10	183		915	40
41	Exit Devices @ Bldg A Von Duprin	2012	3,651	183	10	183		915	41
42	New Freezer Compressor	2012	5,271	264	10	264		1,320	42
43	Rebuilt series 80 pumps #1,#2, #3	2012	5,062	253	10	253		1,265	43
44	Resurfacing Parking Lot	2012	122,272	7,642	8	7,642		38,210	44
45	Gazebo Improvements - Foundation	2012	7,250	967	3.75	967		4,835	45
46									46
47	14x24 Garage Wood-donation	2013	5,870	391	15	391		1,272	47
48	Replae Module in Fireye Boiler	2013	5,844	584	10	584		2,240	48
49	Rebuild Hot Water Pump in Service	2013	3,755	376	10	376		1,439	49
50	Replace HW Valve on Air Handler	2013	3,661	366	10	366		1,403	50
51	Insulation Work On Trane 300 Ton	2013	3,201	213	15	213		747	51
52	Repair Lochinar Boilers	2013	5,153	429	12	429		1,467	52
53	Replace Parts for 300 Ton Chillers	2013	3,865	258	15	258		859	53
54	Replace Pontentiometer and Switch	2013	4,328	361	12	361		1,112	54
55	Remodel Admin office for 2 persons	2013	4,500	450	10	450		1,388	55
56	Hot water Pump #2 Bearing assembly	2013	4,791	479	10	479		1,517	56
57									57
58	Completion of Potenitiometer & Switch in Boiler	2014	3,360	336	10	336		1,016	58
59	Repair to sprinkler system	2014	3,837	320	12	320		959	59
60	Replace Expansion Valves on Chiller	2014	4,488	299	15	299		823	60
61	Replace boiler #1	2014	4,631	463	10	463		1,274	61
62	Generator control panel & primer pump	2014	15,502	1,292	12	1,292		3,445	62
63	Replace condenser Fan motor on chiller	2014	4,264	284	15	284		758	63
64	Freezer door in kitchen	2014	4,717	629	7.5	629		1,361	64
65									65
66	New concrete sidewalk	2015	3,500	233	15	233		408	66
67	Replace Fusible Switch in Main	2015	2,503	250	10	250		438	67
68	Rebuild Chilled Water Pump #1	2015	6,136	614	10	614		1,074	68
69	Replace 3 motors due to short	2015	3,189	319	10	319		558	69
70	TOTAL (lines 4 thru 69)		$ 12,116,158	$ 514,913		$ 514,913	$	$ 8,260,597	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: 01/01/2016 Ending: 12/31/2016

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	$ 514,913		$ 514,913	$	$ 8,260,597	1
2	Replaced Bolted pressure switch	2015	12,922	861	15	861		1,435	2
3	Hot water lines building A&B	2015	5,437	555	9.8	555		878	3
4	Replace Oil Pressure Switches	2015	3,936	262	15	262		371	4
5									5
6	Two Trane Compressors -Roof	2016	73,744	3,073	5	3,073		3,073	6
7	Wandering Patient System - Throughout Building	2016	70,058	5,838	10	5,838		5,838	7
8	Painting - CVS Halls & Dining Room	2016	6,739	449	5	449		449	8
9	Window Blinds - Throughout Building	2016	3,885	55	10	55		55	9
10									10
11									11
12									12
13									13
14	Adjustment to Financial Statements			(4,144)			4,144		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)		$ 12,292,879	$ 521,863		$ 526,007	$ 4,144	$ 8,272,697	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: 01/01/2016 Ending: 12/31/2016

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	$ 535,247	$ 60,496	$ 60,496	$ -	5-20	$ 359,178	71
72	Current Year Purchases	44,595	4,027	4,027	-	5-10	4,027	72
73	Fully Depreciated Assets	1,223,069			-		1,223,069	73
74					-			74
75	TOTALS	$ 1,802,911	$ 64,523	$ 64,523	$ -		$ 1,586,274	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	2015 GMC Sierra w/plow	2015	$ 32,974	$ 6,595	$ 6,595	$ -	5	$ 12,640	76
77							-			77
78					-	-	-			78
79					-	-	-			79
80	TOTALS			$ 32,974	$ 6,595	$ 6,595	$ -		$ 12,640	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)	$ 14,211,862	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 592,981	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 597,125	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,144	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,871,611	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	CIP	$ 116,663	92
93			93
94			94
95		$ 116,663	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: 01/01/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 46,441 Description: Nursing Equipment $35,581, Maintenance $1,094, Copy & Postage Machine $9,766
(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: 01/01/2016 Ending: 12/31/2016

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.

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	$	4,602	$ 303,864	$	4,602	$ 303,864	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,630	106,089		1,630	106,089	2
3	Licensed Recreational Therapist		hrs		5,569	367,990		5,569	367,990	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				215,828		215,828	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapist	39(3)			1,710	94,050		1,710	94,050	12
13	Other (specify): Oxygen	39(2)					51,661		51,661	13
14	TOTAL			$	13,511	$ 871,993	$ 267,489	13,511	$ 1,139,482	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 & Nrsing **#** 0044321 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 769,107	$ 769,107	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 288,822)	2,147,860	2,147,860	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	4,365,074	4,365,074	5
6	Prepaid Insurance	88,851	88,851	6
7	Other Prepaid Expenses	131,675	131,675	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)**	$ 7,506,559	$ 7,506,559	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	12,256,142	11,005,557	14
15	Leasehold Improvements, at Historical Cost	1,127,630	1,287,322	15
16	Equipment, at Historical Cost	1,780,253	1,835,885	16
17	Accumulated Depreciation (book methods)	(10,056,984)	(9,871,611)	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	116,663	116,663	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,306,802	$ 4,456,914	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,813,361	$ 11,963,473	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 613,790	$ 613,790	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	168,002	168,002	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	87,663	87,663	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interest Payable & Work Comp. Res.	441,890	441,890	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,311,345	$ 1,311,345	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	350,653	350,653	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 350,653	$ 350,653	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,661,998	$ 1,661,998	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,151,363	$ 10,301,475	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,813,361	$ 11,963,473	48

***(See instructions.)**

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,733,782	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	536,168	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,269,950	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	881,413	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)**	$ 881,413	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)**	$ 11,151,363	24 *

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 13,964,998	1
2	Discounts and Allowances for all Levels	(3,051,092)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,913,906	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,774,545	6
7	Oxygen	155,752	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,930,297	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	126,855	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,990	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	235,011	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,715	19
20	Radiology and X-Ray	10,079	20
21	Other Medical Services	814,914	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,209,564	23
	D. Non-Operating Revenue		
24	Contributions	33,304	24
25	Interest and Other Investment Income***	47,221	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 80,525	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Sch 19A	167,541	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 167,541	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,301,833	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,289,504	31
32	Health Care	6,131,459	32
33	General Administration	3,622,613	33
	B. Capital Expense		
34	Ownership	683,637	34
	C. Ancillary Expense		
35	Special Cost Centers	1,254,629	35
36	Provider Participation Fee	438,578	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,420,420	40
41	**Income before Income Taxes (line 30 minus line 40)****	881,413	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 881,413	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,820,976	44
45	Private Pay - Net Inpatient Revenue	4,409,173	45
46	Medicare - Net Inpatient Revenue	1,683,757	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,913,906	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: **12/31/2016**

Schedule 19A

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

Description	Amount
M/C Cost Report Settlement	60,770
Maintenance	31
Miscellaneous	106,740
Total - Line 28	**167,541**

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	2,020	2,464	$ 111,059	$ 45.07	1
2	Assistant Director of Nursing	1,852	2,040	72,501	35.54	2
3	Registered Nurses	35,623	39,472	1,180,872	29.92	3
4	Licensed Practical Nurses	13,964	15,336	375,490	24.48	4
5	CNAs & Orderlies	135,544	145,826	1,913,513	13.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,141	11,519	193,146	16.77	8
9	Activity Director	1,697	2,015	42,544	21.11	9
10	Activity Assistants	79,657	8,486	77,745	9.16	10
11	Social Service Workers	7,537	8,528	172,685	20.25	11
12	Dietician	2,376	2,680	50,254	18.75	12
13	Food Service Supervisor	1,969	2,210	56,640	25.63	13
14	Head Cook	1,716	1,938	25,967	13.40	14
15	Cook Helpers/Assistants	5,630	6,547	80,383	12.28	15
16	Dishwashers	39,228	41,314	374,133	9.06	16
17	Maintenance Workers	6,134	6,434	123,209	19.15	17
18	Housekeepers	21,021	22,962	230,179	10.02	18
19	Laundry	5,629	6,210	66,900	10.77	19
20	Administrator	2,080	2,080	104,672	50.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,917	15,397	212,178	13.78	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	33,175	36,914	886,796	24.02	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	420,910	380,372	$ 6,350,866 *	$ 16.70	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	577	$ 29,590	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	698	42,712	10(3)	37
38	Nurse Consultant	Monthly	1,545	10(3)	38
39	Pharmacist Consultant	Flat Fee	18,490	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	31	1,545	11(3)	44
45	Social Service Consultant	8	658	12(3)	45
46	Other(specify)				46
47	Nursing Dental	Flat Fee	900	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	1,314	$ 101,440		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,092	$ 94,876	10(3)	50
51	Licensed Practical Nurses	7,156	311,837	10(3)	51
52	Certified Nurse Assistants/Aides	14,328	339,360	10(3)	52
53	TOTAL (lines 50 - 52)	23,576	$ 746,073		53

Facility Name: **DeKalb County Rehab & Nrsing**
IDPH License ID Number: **0044321**
Fiscal Year End: **12/31/2016**

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	1,248	1,344	40,615	$ 30.22
Care Plan Coordinator	1,819	2,075	68,105	$ 32.82
House Supervisor	4,116	4,791	192,434	$ 40.17
Scheduling Coordinator	1,916	2,365	43,167	$ 18.25
Clinical Support Services Coordinator	1,191	1,276	32,471	$ 25.45
CVS Department Head	1,918	2,210	76,009	$ 34.39
Unit Clerk and Assistant	9,662	10,133	109,169	$ 10.77
Medicare Case Manager	5,067	5,490	184,596	$ 33.62
Nursing Secretary	2,396	2,725	55,355	$ 20.31
Ward Secretary	3,842	4,505	84,875	$ 18.84
Total - Line 32 Other Health Care (specify):	**33,175**	**36,914**	**886,796**	**$ 24.02**

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bart Becker	Administrator	0	$ 104,672
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,672

B. Administrative - Other

Description	Amount
Management Performance Associates	$ 159,509
TOTAL (agree to Schedule V, line 17, col. 3)	$ 159,509
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21C		$ 214,815
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 214,815

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,382
Unemployment Compensation Insurance	25,638
FICA Taxes	475,515
Employee Health Insurance	1,243,203
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	609,633
Tort & Liability Fund (Work Comp)	6,412
Health Savings Account	8,544
Uniform Allowance	20,580
Employee Medical Expense	6,330
Employee Life Insurance	12,012
Allocated FICA/IMRF	87,339
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,563,588

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	$ 995
Advertising: Employee Recruitment	55,969
Health Care Worker Background Check	2,395
(Indicate # of checks performed 66)	
Patient Background Checks 204	2,040
Life Services Network of Illinois dues	9,279
Less Lobbying Dues	(2,762)
Miscellaneous Dues & Subscriptions	1,586
HealthCare Information Subscription	
Leading Age	4,530
Less: Public Relations Expense	( )
Non-allowable advertising	(4,210)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 69,822

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,780
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,780

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **DeKalb County Rehab & Nrsing**
IDPH License ID Number: **0044321**
Fiscal Year End: **12/31/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	34,715
Laner Muchin Dombrow Becker	Legal	6,309
Polsinelli Shughart PC	Legal	16,047
Myers Carden & Sax LLC	Legal	27,290
Stricklin & Associates	Legal	8,000
Foster 7 Buick	Legal	15,496
Pinnacle Consulting	Operations Consultant	2,875
Management Performance Associates	Operations Consultant	42,222
Management Performance Associates	Operations Consultant	41,779
Management Performance Associates	Operations Consultant	9,487
Helen Turner	CPR Instructor	4,400
David Kuo, D.O. FACP	Expert Physician Witness Consultant	6,195
	Total (agree to Schedule V, line 19, column 3)	214,815
Allocated from Management Company	Legal Fees	
Allocated from Management Company	Professional Services	7,763
Less: Non-Allowable Legal Fees		(17,906)
	Total (agree to Schedule V, line 19, column 8)	204,672

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 - $13,808**

(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? **5-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **75,668** 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. $ **438,578**
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. $ **-** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,990**

(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