		FOR BHF USE					

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0044321

Facility Name: DeKalb County Rehab & Nursing Center

Address: 2600 N. Annie Glidden Rd. (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 1/1/18 to 12/31/18 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 & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	720	120	8,032	8,872	8
9	SNF/PED					9
10	ICF	29,813	18,395	9,434	57,642	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,533	18,515	17,466	66,514	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.91%

D. How many bed reserve days during this year were paid by the Department?
N/A (Do not include bed reserve 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 6,420

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	613,812	53,169	40,627	707,608		707,608	-	707,608			1
2	Food Purchase		485,296		485,296		485,296	(3,163)	482,133			2
3	Housekeeping	234,887	53,706	147,086	435,679		435,679	-	435,679			3
4	Laundry	60,229	15,308	-	75,537		75,537	-	75,537			4
5	Heat and Other Utilities			330,541	330,541		330,541	(321)	330,220			5
6	Maintenance	129,771	79,163	133,778	342,712		342,712	7,834	350,546			6
7	Other (specify):*	-	-	-				-				7
8	**TOTAL General Services**	1,038,699	686,642	652,032	2,377,373		2,377,373	4,350	2,381,723			8
	B. Health Care and Programs											
9	Medical Director	-	-	4,800	4,800		4,800	-	4,800			9
10	Nursing and Medical Records	4,967,155	304,618	1,406,710	6,678,483		6,678,483	-	6,678,483			10
10a	Therapy	191,352	-	-	191,352		191,352	-	191,352			10a
11	Activities	127,749	2,572	17,949	148,270		148,270	-	148,270			11
12	Social Services	165,962	118	658	166,738		166,738	-	166,738			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	3,072	3,072		3,072	-	3,072			14
15	Other (specify):*	-	-	-				-				15
16	**TOTAL Health Care and Programs**	5,452,218	307,308	1,433,189	7,192,715		7,192,715		7,192,715			16
	C. General Administration											
17	Administrative	110,144	-	207,065	317,209		317,209	70,232	387,441			17
18	Directors Fees			-				-				18
19	Professional Services			230,377	230,377		230,377	(18,442)	211,935			19
20	Dues, Fees, Subscriptions & Promotions			27,302	27,302		27,302	(5,762)	21,540			20
21	Clerical & General Office Expenses	201,897	58,081	193,162	453,140		453,140	238,117	691,257			21
22	Employee Benefits & Payroll Taxes			2,564,902	2,564,902		2,564,902	98,440	2,663,342			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			4,849	4,849		4,849	-	4,849			24
25	Other Admin. Staff Transportation		-	3,527	3,527		3,527	-	3,527			25
26	Insurance-Prop.Liab.Malpractice			92,591	92,591		92,591	23,492	116,083			26
27	Other (specify):*	-	-	-				-				27
28	**TOTAL General Administration**	312,041	58,081	3,323,775	3,693,897		3,693,897	406,077	4,099,974			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,802,958	1,052,031	5,408,996	13,263,985		13,263,985	410,427	13,674,412			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number DeKalb County Rehab & Nursing Center #0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			591,364	591,364		591,364	(4,834)	586,530			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			-				-				32
33	Real Estate Taxes			-				-				33
34	Rent-Facility & Grounds			-				-				34
35	Rent-Equipment & Vehicles			56,171	56,171		56,171	-	56,171			35
36	Other (specify):*			-				-				36
37	**TOTAL Ownership**			647,535	647,535		647,535	(4,834)	642,701			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	2,551	2,551		2,551	-	2,551			38
39	Ancillary Service Centers	-	324,192	804,980	1,129,172		1,129,172	(4,617)	1,124,555			39
40	Barber and Beauty Shops	-	-	-				-				40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			521,040	521,040		521,040	-	521,040			42
43	Other (specify):* Non-Allowable Cos	-	-	48,877	48,877		48,877	(48,877)				43
44	**TOTAL Special Cost Centers**		324,192	1,377,448	1,701,640		1,701,640	(53,494)	1,648,146			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,802,958	1,376,223	7,433,979	15,613,160		15,613,160	352,099	15,965,259			45

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	(3,163)	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	(4,260)	30		9
10	Interest and Other Investment Income				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	(27,191)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,744)	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 PG5A	(71,485)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (107,843)		$	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)	459,942		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 459,942		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 352,099		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

DeKalb County Rehab & Nursing Center
ID# 0044321
Report Period Beginning: 1/1/18
Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing & Public Relations	$ (3,524)	43	1
2	Labs - Part A	(22,836)	43	2
3	X-Rays - Part A	(12,792)	43	3
4	Community Relations	(5,823)	43	4
5	Disallow Non-Allowable Advertising	(3,965)	20	5
6	Lobbying Offset	(1,797)	20	6
7	Miscellaneous Income	(13,078)	21	7
8	Disallow Outpatient Therapy - Ancillary	(4,617)	39	8
9	Disallow Outpatient Therapy - Depreciation	(574)	30	9
10	Disallow Outpatient Therapy - Maintenance	(321)	5	10
11	Disallow Contribution to Public Health	(2,158)	43	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(71,485)		49

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 153,539	DeKalb County, Illinois	100.00%	$ 153,539	$	1
2	V	22	FICA Taxes	508,715	DeKalb County, Illinois	100.00%	508,715		2
3	V	22	IMRF	631,435	DeKalb County, Illinois	100.00%	631,435		3
4	V	22	Health Insurance	1,312,260	DeKalb County, Illinois	100.00%	1,312,260		4
5	V	22	Workers Comp	23,667	DeKalb County, Illinois	100.00%	23,667		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			$ 2,629,616			$ 2,629,616	$ *	14

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	DeKalb County, Illinois	100.00%	$ 7,834	$ 7,834	15
16	V	17	County Board Costs		DeKalb County, Illinois	100.00%	70,232	70,232	16
17	V	19	State's Attorney		DeKalb County, Illinois	100.00%	8,749	8,749	17
18	V	21	Departmental and non-departmental costs		DeKalb County, Illinois	100.00%	251,195	251,195	18
19	V	22	Employee Benefit		DeKalb County, Illinois	100.00%	29,074	29,074	19
20	V	22	Employee Benefit-G&A		DeKalb County, Illinois	100.00%	69,366	69,366	20
21	V	26	Risk Management		DeKalb County, Illinois	100.00%	23,492	23,492	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			$			$ 459,942	$ * 459,942	39

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	OPERATING BOARD								$		1
2	Greg Millburg	Member	Administrative							N/A	2
3	Ferald Bryan	Member	Administrative							N/A	3
4	Missy Haji-Sheikh	Member	Administrative							N/A	4
5	Rita Nielsen	Member	Administrative							N/A	5
6	Jeff Whelan	Member	Administrative							N/A	6
7											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 & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: DeKalb County, Illinois
Street Address: 110 E. Sycamore St.
City / State / Zip Code: Sycamore, IL 610178
Phone Number: ((815) 895-7189
Fax Number: ((815) 895-7187

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	*	*	*	$ 7,834	$		$	1
2	17	County Board Costs	*	*	*	70,232				2
3	19	State's Attorney	*	*	*	8,749				3
4	21	Departmental and Non Departmer	*	*	*	251,195				4
5	22	Employee Benefits-G&A	*	*	*	29,074				5
6	22	Employee Benefits	*	*	*	69,366				6
7	26	Risk Management	*	*	*	23,492				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					$ 459,942	$		$	25

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)	2017	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 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.)**	Alloc Fr. Mgmt 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:			
	2013	N/A	8
	2014		9
	2015		10
	2016		11
	2017		12

County Facility - exempt from real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 8,202,215	4
5			2000	2000	117663	4,707	25	4,707		88643	5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Construction Cap. Rpt cost - new building 3/9/00		1999	1999	12,293	-	10 to 20	-		12,293	9
10	Construction Cap. Rpt cost - new building 3/9/00		2000	2000	10,553	567	15 to 25	567		10,553	10
11	Cap. Rpt. Costs - new building since 3/9/00		2000	2000	37,957	-	10 to 25	-		37,957	11
12	Maint. Building see fac. Letter and OHF rpt 6/18/01		2000	2000	109,759	5,488	20	5,488		103,357	12
13	Electric,Acoustical duct repair,seal coat dry wall		2001	2001	21,941	830	5 to 24	830		17,575	13
14	Half gate,workstation,swing door,gazebo, & concrete		2001	2001	63,596	-	15 to 20	-		63,596	14
15	Duct repair,dumpster,slab,stainless steel-kitchen		2002	2002	10,421	485	5 to 25	485		10,311	15
16	Employee entrance & courtyard landscaping		2003	2003	11,355	-	10	-		11,355	16
17	Locks on doors, stainless steel walls dietary,lot lights		2004	2004	30,177	-	6 to 15	-		30,177	17
18	Maint. Mezzanine, replace fire system, fire lane, compressor		2005	2005	24,617	-	5 to 20	-		24,617	18
19	Architect,construction,painting,programming, dementia uni		2005	2005	339,823	-	20	-		339,823	19
20	Mirror,painting,replace concrete CVS,replace 29 sprinklers		2006	2006	9,978	-	5 to 18	-		9,978	20
21	Replace 2 doors, add magnets, install magnets & smoke dete		2006	2006	13,813	1,002	5	1,002		12,288	21
22	Painting in dining rooms		2007	2007	7,840	-	5	-		7,840	22
23	Replace 600aMP Switch		2007	2007	4,847	373	13	373		4,412	23
24	New Phone System		2007	2007	22,000	-	10	-		22,000	24
25	New Phone System (Final)		2007	2007	50,589	-	10	-		50,589	25
26	Steel Doors		2008	2008	3,290	165	20	165		1,756	26
27	Fencing		2008	2008	21,179	1,412	15	1,412		14,237	27
28	Magnetic Gate		2009	2009	2,887	280	10	280		2,759	28
29	Upgrade controls		2009	2009	7,904	790	10	790		7,771	29
30	Wood wrap on Front Columns		2009	2009	6,940	463	15	463		4,474	30
31	Repair Dietary Floor		2009	2009	7,800	390	20	390		3,770	31
32	New Door by laundry		2009	2009	5,290	353	15	353		3,410	32
33	New Canopy in CVS		2009	2009	3,063	204	15	204		1,956	33
34	New Concrete around building		2009	2009	15,996	1,066	15	1,066		10,038	34
35						-		-			35
36						-		-			36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 2,130	37
38	Replace Fire Eye Controller	2011	3,601	300	12	300		2,250	38
39				-		-			39
40	Exit Devices @ CVS Von Duprin	2012	3,651	183	10	183		1,281	40
41	Exit Devices @ Bldg A Von Duprin	2012	3,651	183	10	183		1,281	41
42	New Freezer Compressor	2012	5,271	264	10	264		1,848	42
43	Rebuilt series 80 pumps #1,#2, #3	2012	5,062	253	10	253		1,771	43
44	Resurfacing Parking Lot	2012	122,272	7,642	8	7,642		53,494	44
45	Gazebo Improvements - Foundation	2012	7,250	967	3.75	967		6,769	45
46				-		-			46
47	14x24 Garage Wood-donation	2013	5,870	391	15	391		2,055	47
48	Replae Module in Fireye Boiler	2013	5,844	584	10	584		3,409	48
49	Rebuild Hot Water Pump in Service	2013	3,755	376	10	376		2,190	49
50	Replace HW Valve on Air Handler	2013	3,661	366	10	366		2,136	50
51	Insulation Work On Trane 300 Ton	2013	3,201	213	15	213		1,174	51
52	Repair Lochinar Boilers	2013	5,153	429	12	429		2,326	52
53	Replace Parts for 300 Ton Chillers	2013	3,865	258	15	258		1,374	53
54	Replace Pontentiometer and Switch	2013	4,328	361	12	361		1,833	54
55	Remodel Admin office for 2 persons	2013	4,500	450	10	450		2,288	55
56	Hot water Pump #2 Bearing assembly	2013	4,791	479	10	479		2,475	56
57				-		-			57
58	Completion of Potenitiometer & Switch in Boiler	2014	3,360	336	10	336		1,688	58
59	Repair to sprinkler system	2014	3,837	320	12	320		1,599	59
60	Replace Expansion Valves on Chiller	2014	4,488	299	15	299		1,421	60
61	Replace boiler #1	2014	4,631	463	10	463		2,200	61
62	Generator control panel & primer pump	2014	15,502	1,292	12	1,292		6,029	62
63	Replace condenser Fan motor on chiller	2014	4,264	284	15	284		1,326	63
64	Freezer door in kitchen	2014	4,717	629	7.5	629		2,619	64
65				-		-			65
66	New concrete sidewalk	2015	3,500	233	15	233		875	66
67	Replace Fusible Switch in Main	2015	2,503	250	10	250		939	67
68	Rebuild Chilled Water Pump #1	2015	6,136	614	10	614		2,301	68
69	Replace 3 motors due to short	2015	3,189	319	10	319		1,196	69
70	TOTAL (lines 4 thru 69)		$ 12,116,158	$ 473,113		$ 473,113	$	$ 9,224,026	70

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 473,113		$ 473,113	$	$ 9,224,026	1
2	Replaced Bolted pressure switch	2015	12,922	861	15	861		3,158	2
3	Hot water lines building A&B	2015	5,437	555	9.8	555		1,988	3
4	Replace Oil Pressure Switches	2015	3,936	262	15	262		896	4
5				-		-			5
6	Two Trane Compressors -Roof	2016	73,744	14,749	5	14,749		32,571	6
7	Wandering Patient System - Throughout Building	2016	70,058	7,006	10	7,006		19,850	7
8	Painting - CVS Halls & Dining Room	2016	6,739	1,348	5	1,348		3,145	8
9	Window Blinds - Throughout Building	2016	3,885	389	10	389		833	9
10				-		-			10
11	Door Upgrade - Kitchen	2017	6,850	685	10	685		1,256	11
12	Demo and Replace 9 squares of concrete - Sidewalk by	2017	7,500	750	10	750		1,313	12
13	Employee Entrance			-		-			13
14				-		-			14
15	Vibration Isolators - Administration	2018	7,302	122	10	122		122	15
16	Vibration Isolators - Boiler Room	2018	3,896	65	10	65		65	16
17	Fire Alarm System - Entire Building	2018	18,013	100	15	100		100	17
18				-		-			18
19				-		-			19
20	Adjustment to Financial Statements			4,834		-	(4,834)		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)		$ 12,336,440	$ 504,839		$ 500,005	$ (4,834)	$ 9,289,323	34

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 612,772	$ 72,429	$ 72,429	$ -	5-20 years	$ 498,712	71
72	Current Year Purchases	80,628	7,501	7,501	-	5 years	7,501	72
73	Fully Depreciated Assets	1,175,424			-		1,175,424	73
74					-			74
75	TOTALS	$ 1,868,824	$ 79,930	$ 79,930	$		$ 1,681,637	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	$ 25,830	76
77					-	-	-			77
78					-	-	-			78
79					-	-	-			79
80	TOTALS			$ 32,974	$ 6,595	$ 6,595	$		$ 25,830	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)	$ 14,321,336	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 591,364	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 586,530	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,834)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,996,790	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	$ 1,302,947	92
93			93
94			94
95		$ 1,302,947	95

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

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 ☒ N/A ☐ 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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 56,171 Description: Nursing Equipment $43,707, Maintenance $1,163, Copy & Postage Machine $11,301
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	3,996	$ 266,570	$	3,996	$ 266,570	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,016	75,598		1,016	75,598	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,256	357,569		5,256	357,569	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				261,436		261,436	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(3)			1,635	100,626		1,635	100,626	12
13	Other (specify): Oxygen	39(2)					62,756		62,756	13
14	TOTAL			$	11,903	$ 800,363	$ 324,192	11,903	$ 1,124,555	14

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

STATE OF ILLINOIS

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 3,912,873	$ 3,912,873	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 232,302)	4,798,864	4,798,864	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	173,225	173,225	5
6	Prepaid Insurance	88,851	88,851	6
7	Other Prepaid Expenses	124,494	124,494	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Sr. Living Facility - Dev.	3,993	3,993	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,102,300	$ 9,102,300	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	1,171,191	1,330,883	15
16	Equipment, at Historical Cost	1,854,172	1,901,798	16
17	Accumulated Depreciation (book methods)	(11,191,420)	(10,996,790)	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	1,302,947	1,302,947	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,476,130	$ 4,627,493	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,578,430	$ 13,729,793	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 756,536	$ 756,536	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	210,234	210,234	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	Work Comp. Res.	83,315	83,315	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,137,748	$ 1,137,748	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)**	$ 1,488,401	$ 1,488,401	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,090,029	$ 12,241,392	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,578,430	$ 13,729,793	48

***(See instructions.)**

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,555,894	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(94,856)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,461,038	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	628,991	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)**	$ 628,991	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)**	$ 13,090,029	24 *

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

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 14,978,814	1
2	Discounts and Allowances for all Levels	(3,090,356)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,888,458	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,408,272	6
7	Oxygen	143,707	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,551,979	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	135,454	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,163	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	296,953	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,444	19
20	Radiology and X-Ray	15,545	20
21	Other Medical Services	931,333	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,403,892	23
	D. Non-Operating Revenue		
24	Contributions	305,830	24
25	Interest and Other Investment Income***	78,934	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 384,764	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See SCH 19A	13,059	28
28a	Medicare Cost Report Settlement	(1)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,058	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,242,151	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,377,373	31
32	Health Care	7,192,715	32
33	General Administration	3,693,897	33
	B. Capital Expense		
34	Ownership	647,535	34
	C. Ancillary Expense		
35	Special Cost Centers	1,180,600	35
36	Provider Participation Fee	521,040	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,613,160	40
41	**Income before Income Taxes (line 30 minus line 40)****	628,991	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 628,991	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,118,474	44
45	Private Pay - Net Inpatient Revenue	5,252,250	45
46	Medicare - Net Inpatient Revenue	1,517,734	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,888,458	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.**

^ **Entity is a cash basis taxpayer**

Facility Name: **DeKalb County Rehab & Nursing Center**
IDPH License ID Number: **0044321**
Fiscal Year End: **12/31/18**

Schedule 19A

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

	Description	Amount
01-3980-3011	Current Property Tax Levy	(19)
01-3980-5899	Miscellaneous	13,078
	Total - Line 28	**13,059**

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	2,104	2,297	$ 107,039	$ 46.60	1
2	Assistant Director of Nursing	2,142	2,322	77,611	33.42	2
3	Registered Nurses	49,314	53,989	1,698,416	31.46	3
4	Licensed Practical Nurses	15,591	17,080	715,526	41.89	4
5	CNAs & Orderlies	109,983	119,387	1,334,268	11.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,521	10,817	191,352	17.69	8
9	Activity Director	1,900	2,015	46,609	23.13	9
10	Activity Assistants	7,245	8,354	81,140	9.71	10
11	Social Service Workers	7,683	8,451	165,962	19.64	11
12	Dietician					12
13	Food Service Supervisor	6,220	6,803	138,687	20.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,868	9,670	109,278	11.30	15
16	Dishwashers	37,469	39,304	365,847	9.31	16
17	Maintenance Workers	5,908	6,536	129,771	19.85	17
18	Housekeepers	20,360	22,639	234,887	10.38	18
19	Laundry	4,999	5,933	60,229	10.15	19
20	Administrator	1,544	1,544	110,144	71.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,663	15,042	201,897	13.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: See Sch 20A	35,871	40,799	1,034,295	25.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	340,385	372,982	$ 6,802,958 *	$ 18.24	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	Monthly	$ 40,627	1(3)	35
36	Medical Director	Monthly	4,800	9(3)	36
37	Medical Records Consultant	Monthly	15,972	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Flat Fee	19,094	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	8	390	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	Restorative Consultant	Monthly	289	10(3)	48
49	TOTAL (lines 35 - 48)	16	$ 82,730		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,082	$ 53,008	10(3)	50
51	Licensed Practical Nurses	4,237	183,483	10(3)	51
52	Certified Nurse Assistants/Aides	38,545	1,133,964	10(3)	52
53	TOTAL (lines 50 - 52)	43,864	$ 1,370,455		53

Facility Name: **DeKalb County Rehab & Nursing Center**
IDPH License ID Number: **0044321**
Fiscal Year End: **12/31/18**

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	1,827	1,946	62,032	$ 31.88
Care Plan Coordinator	1,842	2,053	67,598	$ 32.93
House Supervisor	5,557	6,570	258,480	$ 39.34
Scheduling Coordinator	3,381	3,791	61,353	$ 16.18
Clinical Support Services Coordinator	784	972	27,893	$ 28.70
CVS Department Head	1,868	2,195	78,333	$ 35.69
Unit Clerk and Assistant	8,620	9,477	106,447	$ 11.23
Medicare Case Manager	6,337	6,944	244,955	$ 35.28
Nursing Secretary	2,374	2,718	54,090	$ 19.90
Ward Secretary	3,281	4,133	73,114	$ 17.69
Total - Line 32 Other Health Care (specify):	**35,871**	**40,799**	**1,034,295**	

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bart Becker	Administrator	0	$ 110,144
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 110,144

B. Administrative - Other

Description	Amount
Management Performance Associates	$ 166,024
Roger Herman	41,041
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 207,065

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21C		$ 230,377
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 230,377

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,667
Unemployment Compensation Insurance	25,822
FICA Taxes	508,715
Employee Health Insurance	1,312,260
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	631,435
Tort & Liability Fund (Work Comp)	21,217
Health Savings Account	3,920
Uniform Allowance	19,575
Employee Medical Expense	6,856
Employee Life Insurance	11,435
Allocated FICA/IMRF	98,440
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,663,342

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	4,398
Health Care Worker Background Check	3,500
(Indicate # of checks performed 100)	
Patient Background Checks 196	1,960
LeadingAge	12,834
Less Lobbying Dues	(1,797)
Miscellaneous Dues & Subscriptions	2,620
Less: Public Relations Expense	( )
Non-allowable advertising	(3,965)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,540

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,849
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,849

**See instructions.

Facility Name: **DeKalb County Rehab & Nursing Center**
IDPH License ID Number: **0044321**
Fiscal Year End: **12/31/18**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	12,075
Laner Muchin	Legal	6,000
Polsinelli Shughart PC	Legal	56,002
Carden & Sax LLC	Legal	25,066
Lashly & Baer	Legal	2,508
Stricklin & Associates	Consultant	12,000
Pinnacle Consulting	Operations Consultant	3,008
Management Performance Associates	Operations Consultant	43,511
Management Performance Associates	Operations Consultant	43,499
Management Performance Associates	Operations Consultant	13,575
Helen Turner	Operations Consultant	4,440
Angela Busse	Business Office Assistant	5,381
Gretchen Butts	Consultant	3,267
Celeste Miller	Consultant	45
Total (agree to Schedule V, line 19, column 3)		230,377
Allocated from Management Company Legal Fees		8,749
Less: Non-Allowable Legal Fees		(27,191)
Total (agree to Schedule V, line 19, column 8)		211,935

Facility Name & ID Number DeKalb County Rehab & Nursing Center # 0044321 Report Period Beginning: 1/1/18 Ending: 12/31/18

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. **LeadingAge - $12,834**

(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 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **76,470** 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. $ **521,040**
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. $ **3,163**

(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 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.