

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0044321</u> Facility Name: <u>DeKalb County Rehab & Nrsing</u> Address: <u>2600 N Annie Glidden</u> <u>DeKalb</u> <u>60115</u> Number City Zip Code County: <u>DeKalb</u> Telephone Number: <u>(815) 758-2477</u> Fax # <u>(815) 217-0451</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>7/15/54</u> Type of Ownership: <table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☒</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☒</td><td>County</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td>_____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Trust</td><td>☐</td><td>_____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Other</td><td>☐</td><td>_____</td></tr></table> IRS Exemption Code _____ In the event there are further questions about this report, please contact: Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u> Email Address: _____	☐	VOLUNTARY,NON-PROFIT	☐	PROPRIETARY	☒	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☒	County	☐		☐	Corporation	☐	Other _____	☐		☐	"Sub-S" Corp.	☐	_____	☐		☐	Limited Liability Co.	☐	_____	☐		☐	Trust	☐	_____	☐		☐	Other	☐	_____	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> 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. <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____ (Date) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # (847)517-7067</td></tr></table> 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	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # (847)517-7067
☐	VOLUNTARY,NON-PROFIT	☐	PROPRIETARY	☒	GOVERNMENTAL																																																						
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Facility Name & ID Number DeKalb County Rehab & Nrsing# 0044321 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>190</u>	Skilled (SNF)	<u>190</u>	<u>69,540</u>	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	<u>190</u>	TOTALS	<u>190</u>	<u>69,540</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>5,104</u>	<u>5,104</u>	8
9	SNF/PED					9
10	ICF	<u>27,383</u>	<u>19,073</u>		<u>46,456</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,383</u>	<u>19,073</u>	<u>5,104</u>	<u>51,560</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.14%

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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Note : Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/09/2000

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date _____

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 190 and days of care provided 5,104

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2020Fiscal Year: 12/31/2020

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

Facility Name & ID Number DeKalb County Rehab & Nrsing # 0044321 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	676,387	48,001	32,125	756,513		756,513	13,126	769,639			1
2	Food Purchase		425,598		425,598		425,598	(215)	425,383			2
3	Housekeeping	239,467	43,752	542,275	825,494		825,494		825,494			3
4	Laundry	61,896	8,506	-	70,402		70,402		70,402			4
5	Heat and Other Utilities			341,493	341,493		341,493	(92)	341,401			5
6	Maintenance	141,580	67,001	162,531	371,112		371,112	8,761	379,873			6
7	Other (specify):*	-	-	-								7
8	TOTAL General Services	1,119,330	592,858	1,078,424	2,790,612		2,790,612	21,580	2,812,192			8
	B. Health Care and Programs											
9	Medical Director	-	-	3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	4,094,961	492,903	3,406,142	7,994,006		7,994,006	(13,126)	7,980,880			10
10a	Therapy	221,454	-	-	221,454		221,454		221,454			10a
11	Activities	133,324	2,427	8,636	144,387		144,387		144,387			11
12	Social Services	182,761	-	247	183,008		183,008		183,008			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	1,430	1,430		1,430		1,430			14
15	Other (specify):*	-	-	-								15
16	TOTAL Health Care and Programs	4,632,500	495,330	3,420,055	8,547,885		8,547,885	(13,126)	8,534,759			16
	C. General Administration											
17	Administrative	125,008	-	172,031	297,039		297,039	78,539	375,578			17
18	Directors Fees			-								18
19	Professional Services			254,394	254,394		254,394	(82,613)	171,781			19
20	Dues, Fees, Subscriptions & Promotions			70,710	70,710		70,710	(3,317)	67,393			20
21	Clerical & General Office Expenses	223,594	56,881	180,562	461,037		461,037	275,662	736,699			21
22	Employee Benefits & Payroll Taxes			2,092,039	2,092,039		2,092,039	110,082	2,202,121			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			3,819	3,819		3,819		3,819			24
25	Other Admin. Staff Transportation		-	1,169	1,169		1,169		1,169			25
26	Insurance-Prop.Liab.Malpractice			38,814	38,814		38,814	26,271	65,085			26
27	Other (specify):*			-								27
28	TOTAL General Administration	348,602	56,881	2,813,538	3,219,021		3,219,021	404,624	3,623,645			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,100,432	1,145,069	7,312,017	14,557,518		14,557,518	413,078	14,970,596			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			580,927	580,927		580,927	12,973	593,900			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			291,625	291,625		291,625	(55,446)	236,179			32
33	Real Estate Taxes			-								33
34	Rent-Facility & Grounds			-								34
35	Rent-Equipment & Vehicles			46,202	46,202		46,202		46,202			35
36	Other (specify):*			-								36
37	TOTAL Ownership			918,754	918,754		918,754	(42,473)	876,281			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	2,324	2,324		2,324		2,324			38
39	Ancillary Service Centers	-	232,208	557,365	789,573		789,573	(1,339)	788,234			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			391,483	391,483		391,483		391,483			42
43	Other (specify):* Non-Allowable Cos	-	-	99,648	99,648		99,648	(99,648)				43
44	TOTAL Special Cost Centers		232,208	1,050,820	1,283,028		1,283,028	(100,987)	1,182,041			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,100,432	1,377,277	9,281,591	16,759,300		16,759,300	269,618	17,028,918			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(215)	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	13,129	30		9
10	Interest and Other Investment Income	(55,446)	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	(2,925)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(92,397)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,677)	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	(49,192)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (244,723)		\$	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)	514,341		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 514,341		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 269,618		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing & Public Relations	\$ (2,096)	43	1
2	Labs - Part A	(24,157)	43	2
3	X-Rays - Part A	(8,904)	43	3
4	Community Relations	(3,858)	43	4
5	Disallow Non-Allowable Advertising	(2,404)	20	5
6	Lobbying Offset	(913)	20	6
7	Miscellaneous Income	(5,242)	21	7
8	Disallow Outpatient Therapy - Ancillary	(1,339)	39	8
9	Disallow Outpatient Therapy - Depreciation	(156)	30	9
10	Disallow Outpatient Therapy - Maintenance	(92)	5	10
11	Reclass food	13,126	2	11
12	Reclass food	(13,126)	10	12
13	Ice Cream Parlor	(31)	43	13
14				14
15				15
16				16
17				17
18				18
19				19
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21				21
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(49,192)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Department chargeback	\$ 149,768	DeKalb County, Illinois	100	\$ 149,768	\$	1
2	V	22	FICA Taxes	448,370	DeKalb County, Illinois	100	448,370		2
3	V	22	IMRF	545,819	DeKalb County, Illinois	100	545,819		3
4	V	22	Health Insurance	1,048,222	DeKalb County, Illinois	100	1,048,222		4
5	V	22	Workers Comp	(26,682)	DeKalb County, Illinois	100	(26,682)		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			\$ 2,165,497			\$ 2,165,497	\$ *	0 14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	\$	DeKalb County, Illinois	100%	\$ 8,761	\$ 8,761	15
16	V	17	County Board Costs		DeKalb County, Illinois	100%	78,539	78,539	16
17	V	19	State's Attorney		DeKalb County, Illinois	100%	9,784	9,784	17
18	V	21	Departmental and non-departmental costs		DeKalb County, Illinois	100%	280,904	280,904	18
19	V	22	Employee Benefit		DeKalb County, Illinois	100%	26,471	26,471	19
20	V	22	Employee Benefit-G&A		DeKalb County, Illinois	100%	83,611	83,611	20
21	V	26	Risk Management		DeKalb County, Illinois	100%	26,271	26,271	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			\$			\$ 514,341	\$ * 514,341	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: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	OPERATING BOARD								\$		1
2	Jeff Whelan	President	Administrative							N/A	2
3	Rita Nielsen	Vice-President	Administrative							N/A	3
4	Ferald Bryan	Member	Administrative							N/A	4
5	Patrick Conboy	Member	Administrative							N/A	5
6	Steve Kuhn	Member	Administrative							N/A	6
7	Greg Millburg	Member	Administrative							N/A	7
8	Chris Porterfield	Member	Administrative							N/A	8
9											9
10	No members of the operating board provide services to the county.										10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number DeKalb County Rehab & Nrsing# 0044321

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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 ☒ 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	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	Maintenance	*		\$	\$		8,761	1
2	17	County Board Costs	*					78,539	2
3	19	State's Attorney	*					9,784	3
4	21	Departmental and Non Department	*					280,904	4
5	22	Employee Benefits	*					26,471	5
6	22	Employee Benefits-G&A	*					83,611	6
7	26	Risk Management	*					26,271	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				\$	\$		514,341	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	DeKalb County	X		Expansion Project	Interest Only	5/17/2019	\$ 5,000,000	\$	5/16/2020	0.03	\$ 176,701	1	
2												2	
3	Series 2020 Bonds		X	Expansion Project	Varies	9/9/2020	13,000,000	12,740,000	12/15/2050	0.05	112,064	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 18,000,000	\$ 12,740,000			\$ 288,765	9	
	B. Non-Facility Related*												
10												10	
11												11	
12									Interest Income		(55,446)	12	
13									Amortization		2,860	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (52,586)	14	
15	TOTALS (line 9+line14)						\$ 18,000,000	\$ 12,740,000			\$ 236,179	15	

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

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

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

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

B. Real Estate Taxes

[illegible]

NOTES:

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

2019 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 2019 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 2019.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. <u>County Facility - exempt from real e</u>		\$	\$
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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred:	N/A	2. Number of Years Over Which it is Being Amortized:	N/A
----------------------------------	------------	---	------------

3. Current Period Amortization:	N/A	4. Dates Incurred:	N/A
--	------------	---------------------------	------------

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number DeKalb County Rehab & Nrsing

0044321

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	\$	\$ 9,073,247	4
5			2000	2000	117,663	4,707	25	4,707		98,057	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	567	15 to 25	-	(567)	10,553	10
11	Cap. Rpt. Costs - new building since 3/9/00			2000	37,957	-	10 to 25	-		37,957	11
12	Maint. Building see fac. Letter and OHF rpt 6/18/01			2000	109,759	914	20	914		109,759	12
13	Electric,Acoustical duct repair,seal coat dry wall			2001	21,941	830	5 to 24	830		19,235	13
14	Half gate,workstation,swing door,gazebo, & concrete			2001	63,596	-	15 to 20	-		63,596	14
15	Duct repair,dumpster,slab,stainless steel-kitchen,			2002	10,421		5 to 25			10,421	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 unit			2005	322,012	-	20	-		322,012	19
20	Mirror,painting,replace concrete CVS,replace 29 sprinklers			2006	9,978	-	5 to 18	-		9,978	20
21	Replace 2 doors, add magnets, install magnets & smoke detectors			2006	13,813	522	5	522		13,813	21
22	Painting in dining rooms			2007	7,840	-	5	-		7,840	22
23	Replace 600aMP Switch			2007	4,847	62	13	62		4,847	23
24	New Phone System			2007	22,000	-	10	-		22,000	24
25	New Phone System (Final)			2007	50,589	-	10	-		50,589	25
26	Steel Doors			2008	3,290	165	20	165		2,085	26
27	Fencing			2008	21,179	1,412	15	1,412		17,061	27
28	Magnetic Gate			2009	2,887		10			2,887	28
29	Upgrade controls			2009	7,904		10			7,903	29
30	Wood wrap on Front Columns			2009	6,940	463	15	463		5,399	30
31	Repair Dietary Floor			2009	7,800	390	20	390		4,550	31
32	New Door by laundry			2009	5,290	353	15	353		4,115	32
33	New Canopy in CVS			2009	3,063	204	15	204		2,364	33
34	New Concrete around building			2009	15,996	1,066	15	1,066		12,170	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:

1/1/2020

Ending:

12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	HD Swing Operator w/ control	2011	\$ 2,841	\$ 284	10	\$ 284	\$	\$ 2,698	37
38	Replace Fire Eye Controller	2011	3,601	300	12	300		2,850	38
39				-		-			39
40	Exit Devices @ CVS Von Duprin	2012	3,651	183	10	183		1,647	40
41	Exit Devices @ Bldg A Von Duprin	2012	3,651	183	10	183		1,647	41
42	New Freezer Compressor	2012	5,271	264	10	264		2,376	42
43	Rebuilt series 80 pumps #1,#2, #3	2012	5,062	253	10	253		2,277	43
44	Resurfacing Parking Lot	2012	122,272	7,642	8	7,642		68,778	44
45	Gazebo Improvements - Foundation	2012	7,250	-	3.75			7,250	45
46				-		-			46
47	14x24 Garage Wood-donation	2013	5,870	391	15	391		2,837	47
48	Replae Module in Fireve Boiler	2013	5,844	584	10	584		4,578	48
49	Rebuild Hot Water Pump in Service	2013	3,755	376	10	376		2,941	49
50	Replace HW Valve on Air Handler	2013	3,661	366	10	366		2,868	50
51	Insulation Work On Trane 300 Ton	2013	3,201	213	15	213		1,600	51
52	Repair Lochinar Boilers	2013	5,153	429	12	429		3,185	52
53	Replace Parts for 300 Ton Chillers	2013	3,865	258	15	258		1,890	53
54	Replace Pontentiometer and Switch	2013	4,328	361	12	361		2,554	54
55	Remodel Admin office for 2 persons - Removed per 14 CAS	2013		-	10	-			55
56	Hot water Pump #2 Bearing assembly	2013	4,791	479	10	479		3,434	56
57				-		-			57
58	Completion of Potentiometer & Switch in Boiler	2014	3,360	336	10	336		2,360	58
59	Repair to sprinkler system	2014	3,837	320	12	320		2,238	59
60	Replace Expansion Valves on Chiller	2014	4,488	299	15	299		2,019	60
61	Replace boiler #1	2014	4,631	463	10	463		3,126	61
62	Generator control panel & primer pump	2014	15,502	1,292	12	1,292		8,612	62
63	Replace condenser Fan motor on chiller	2014	4,264	284	15	284		1,895	63
64	Freezer door in kitchen	2014	4,717	629	7.5	629		3,877	64
65				-		-			65
66	New concrete sidewalk	2015	3,500	233	15	233		1,342	66
67	Replace Fusible Switch in Main	2015	2,503	250	10	250		1,440	67
68	Rebuild Chilled Water Pump #1	2015	6,136	614	10	614		3,528	68
69	Replace 3 motors due to short	2015	3,189	319	10	319		1,834	69
70	TOTAL (lines 4 thru 69)		\$ 12,093,847	\$ 464,776		\$ 464,209	\$ (567)	\$ 10,138,561	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:

1/1/2020

Ending:

12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,093,847	\$ 464,776		\$ 464,209	\$ (567)	\$ 10,138,561	1
2	Replaced Bolted pressure switch	2015	12,922	861	15	861		4,881	2
3	Hot water lines building A&B	2015	5,437	555	9.8	555		3,097	3
4	Replace Oil Pressure Switches	2015	3,936	262	15	262		1,421	4
5				-		-			5
6	Two Trane Compressors -Roof	2016	73,744	14,749	5	14,749		62,069	6
7	Wandering Patient System - Throughout Building	2016	70,058	7,006	10	7,006		33,862	7
8	Painting - CVS Halls & Dining Room	2016	6,739	1,348	5	1,348		5,841	8
9	Window Blinds - Throughout Building	2016	3,885	389	10	389		1,611	9
10				-		-			10
11	Door Upgrade - Kitchen	2017	6,850	685	10	685		2,626	11
12	Demo and Replace 9 squares of concrete - Sidewalk by	2017	7,500	750	10	750		2,813	12
13	Employee Entrance			-		-			13
14				-		-			14
15	Vibration Isolators - Administration	2018	7,302	730	10	730		1,582	15
16	Vibration Isolators - Boiler Room	2018	3,896	390	10	390	(0)	844	16
17	Fire Alarm System - Entire Building	2018	18,013	1,201	15	1,201	0	2,502	17
18				-		-			18
19	Cooler Door - Kitchen	2019	6,645	664	10	664		1,273	19
20	Compressor In-Trane Chiller - Roof	2019	28,973	2,897	10	2,897		4,346	20
21	Repair Corridor Drywall - Building B	2019	9,163	-	10	916	916	1,374	21
22	Install Door - Dock	2019	3,739	-	10	374	374	561	22
23	Install FRP & Repair Tile - Kitchen	2019	4,856	-	10	486	486	729	23
24	Repair PVC drawins - Penthouse Mechanical Room	2019	2,974	-	10	297	297	446	24
25	Lay Pipe & Surface Parking Lot	2019	4,213	-	10	421	421	632	25
26	Replace Door Controls & Reattach Front Dor	2019	2,586	-	10	259	259	388	26
27	Room 237 improvement, painting, flooring	2020	14,341	876	15	876		876	27
28	LED Recessed Lighting Kits	2020	3,759	564	5	564		564	28
29						-			29
30				-		-			30
31				-		-			31
32	Adjustment to Financial Statements			(10,787)		-	10,787		32
33				-		-			33
34	TOTAL (lines 1 thru 33)		\$ 12,395,378	\$ 487,916		\$ 500,889	\$ 12,973	\$ 10,272,899	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 777,021	\$ 85,575	\$ 85,575	\$	5-20 Years	\$ 667,324	71
72	Current Year Purchases	85,373	6,887	6,887		5	6,887	72
73	Fully Depreciated Assets	1,494,120					1,494,120	73
74								74
75	TOTALS	\$ 2,356,514	\$ 92,462	\$ 92,462	\$		\$ 2,168,331	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	\$ 549	\$ 549	\$	5	\$ 32,974
77					-	-			
78					-	-			
79					-	-			
80	TOTALS			\$ 32,974	\$ 549	\$ 549	\$		\$ 32,974

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	14,867,964
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	580,927
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	593,900
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	12,973
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	12,474,204

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	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$ 14,400,609
93		
94		
95		\$ 14,400,609

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .
9. Option to Buy: YES N/A NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$46,202 Description: Nursing Equipment \$31,985, Maintenance \$1,167, Copy & Postage Machine \$13,050
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.

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	

- (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.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	2,449	\$ 173,279	\$	2,449	\$ 173,279	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		888	83,940		888	83,940	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,020	198,902		3,020	198,902	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				172,440		172,440	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(3)			1,499	92,308		1,499	92,308	12
13	Other (specify): Oxygen	39(2)					59,768		59,768	13
14	TOTAL			\$	7,856	\$ 548,429	\$ 232,208	7,856	\$ 780,637	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,428,861	\$ 2,428,861	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 363,678)	4,935,982	4,935,982	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	1,218,762	1,218,762	5
6	Prepaid Insurance	88,851	88,851	6
7	Other Prepaid Expenses	107,856	107,856	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): <u>Sr. Living Facility - Dev.</u>	3,984	3,984	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,784,296	\$ 8,784,296	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	1,226,167	1,389,821	15
16	Equipment, at Historical Cost	2,007,362	2,389,488	16
17	Accumulated Depreciation (book methods)	(12,340,813)	(12,474,204)	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)	14,400,609	14,400,609	22
23	Other(specify): <u>Issuance Costs 2020 Bond</u>	343,440	343,440	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,976,005	\$ 17,137,809	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 26,760,301	\$ 25,922,105	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,664,100	\$ 1,664,100	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	45,970	45,970	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	<u>See Sch 17A</u>	1,786,926	1,786,926	36
37		-	-	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,584,659	\$ 3,584,659	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	-	-	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	12,740,000	12,740,000	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)	\$ 13,090,653	\$ 13,090,653	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 16,675,312	\$ 16,675,312	46
47	TOTAL EQUITY (page 18, line 24)	\$ 10,084,989	\$ 9,246,793	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 26,760,301	\$ 25,922,105	48

*(See instructions.)

Facility Name:

DeKalb County Rehab & Nrsing

IDPH License ID Number:

0044321

Fiscal Year End:

12/31/2020

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

	After	
Description	Operating	Consolidation
Interest Payable	112,064	112,064
Reserve for W/C Settlements	107,555	107,555
Premium on Bonds	1,567,307	1,567,307
Total - Line 36	1,786,926	1,786,926

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,687,193	1
2	Restatements (describe):		2
3	Prior Period Adjustment	54,490	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,741,683	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,656,694)	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)	\$ (1,656,694)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,084,989	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number DeKalb County Rehab & Nrsing

0044321

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,733,244	1
2	Discounts and Allowances for all Levels	(846,067)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,887,177	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	1,408,932	6
7	Oxygen	127,413	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,536,345	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,551,110	10
11	CNA Training Reimbursements	-	11
12	Gift and Coffee Shop	-	12
13	Barber and Beauty Care	-	13
14	Non-Patient Meals	215	14
15	Telephone, Television and Radio	-	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	195,340	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	65,337	19
20	Radiology and X-Ray	12,940	20
21	Other Medical Services	732,378	21
22	Laundry	-	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,557,320	23
	D. Non-Operating Revenue		
24	Contributions	49,376	24
25	Interest and Other Investment Income***	55,446	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 104,822	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	5,242	28
28a	Reimbursement Revenue	11,700	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,942	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,102,606	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,790,612	31
32	Health Care	8,547,885	32
33	General Administration	3,219,021	33
	B. Capital Expense		
34	Ownership	918,754	34
	C. Ancillary Expense		
35	Special Cost Centers	891,545	35
36	Provider Participation Fee	391,483	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,759,300	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,656,694)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,656,694)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,504,017	44
45	Private Pay - Net Inpatient Revenue	4,067,872	45
46	Medicare - Net Inpatient Revenue	1,315,288	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,887,177	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,064	2,325	\$ 108,866	\$ 46.82	1
2	Assistant Director of Nursing	1,912	2,200	81,929	37.24	2
3	Registered Nurses	44,457	48,729	1,614,534	33.13	3
4	Licensed Practical Nurses	5,729	6,389	160,292	25.09	4
5	CNAs & Orderlies	55,120	60,186	1,025,833	17.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,333	10,658	221,454	20.78	8
9	Activity Director	1,867	2,015	48,606	24.12	9
10	Activity Assistants	7,563	7,916	84,718	10.70	10
11	Social Service Workers	7,905	8,895	182,761	20.55	11
12	Dietician					12
13	Food Service Supervisor	4,761	5,329	116,073	21.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,414	11,414	139,003	12.18	15
16	Dishwashers	37,102	39,193	421,311	10.75	16
17	Maintenance Workers	6,181	6,848	141,580	20.67	17
18	Housekeepers	19,249	21,026	239,467	11.39	18
19	Laundry	5,192	5,682	61,896	10.89	19
20	Administrator	2,080	2,080	125,008	60.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,857	14,983	223,594	14.92	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	36,355	41,068	1,103,507	26.87	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	271,141	296,936	\$ 6,100,432 *	\$ 20.54	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	579	\$ 32,125	1(3)	35
36	Medical Director	Monthly	3,600	9(3)	36
37	Medical Records Consultant	Monthly	10,393	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Flat Fee	14,893	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	2	203	11(3)	44
45	Social Service Consultant	5	247	12(3)	45
46	Other(specify) Rehab	164	7,597	39(3)	46
47	Nursing Dental	Flat Fee	550	10(3)	47
48	Physiatry	Monthly	3,600	10(3)	48
49	TOTAL (lines 35 - 48)	750	\$ 73,208		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,104	\$ 371,113	10(3)	50
51	Licensed Practical Nurses	6,846	341,100	10(3)	51
52	Certified Nurse Assistants/Aides	76,638	2,664,292	10(3)	52
53	TOTAL (lines 50 - 52)	89,588	\$ 3,376,505		53

Facility Name: DeKalb County Rehab & Nrsing
IDPH License ID Number: 0044321
Fiscal Year End: 12/31/2020

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	1,109	1,490	49,643	\$ 33.32
Care Plan Coordinator	1,739	2,039	62,994	\$ 30.89
House Supervisor	6,718	7,372	329,597	\$ 44.71
Scheduling Coord	2,771	3,006	57,377	\$ 19.09
CVS Department Head	1,773	1,917	67,120	\$ 35.01
Unit Clerk and Assistant	8,047	9,299	112,646	\$ 12.11
Medicare Case Manager	4,442	5,065	177,551	\$ 35.05
Nursing Secretary	2,272	2,632	49,865	\$ 18.95
Ward Secretary	5,404	6,168	120,638	\$ 19.56
Corp Compliance Officer	2,080	2,080	76,076	\$ 36.58
Total - Line 32 Other Health Care (specify):	36,355	41,068	1,103,507	

STATE OF ILLINOIS

Facility Name & ID NumberDeKalb County Rehab & Nrsing# 0044321Report Period Beginning:1/1/2020Ending:12/31/2020Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Steven Duchene

Administrator

0

\$ 125,008

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 125,008

B. Administrative - Other

Description

Amount

Management Performance Associates

\$ 172,031

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 172,031

C. Professional Services

Vendor/Payee

Type

Amount

See Sch 21C

\$ 254,394

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 254,394

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ (26,682)

Unemployment Compensation Insurance

19,810

FICA Taxes

448,370

Employee Health Insurance

1,048,222

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

545,819

Tort & Liability Fund (Work Comp)

16,600

Health Savings Account

10,588

Uniform Allowance

16,310

Employee Medical Expense

3,790

Employee Life Insurance

8,524

Allocated FICA/IMRF

110,082

Work Comp Settlements

688

TOTAL (agree to Schedule V, line 22, col.8)

\$ 2,202,121

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

\$ 1,990

Advertising: Employee Recruitment

44,260

Health Care Worker Background Check

(Indicate # of checks performed 101)

3,695

Patient Background Checks

116

LeadingAge

15,220

Less Lobbying Dues

(913)

Miscellaneous Dues & Subscriptions

4,385

Less: Public Relations Expense

()

Non-allowable advertising

(2,404)

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 67,393

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

3,819

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 3,819

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name: DeKalb County Rehab & Nrsing
IDPH License ID Number: 0044321
Fiscal Year End: 12/31/2020

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	12,580
Laner, Muchin Dombrow Becker	Legal-Retainer Fees	7,290
Polsinelli Shughart PC	Legal	23,382
Carden & Tracy	Legal	85,642
Foster & Buick	Legal	648
Stricklin & Associates	Consultant	11,000
Pinnacle Consulting	Operations Consultant	3,090
Management Performance Association	Operations Consultant	91,990
Helen Turner	CPR Instructor	680
Info Controls	Consultant	175
TMA of WI	Department of Health	17,917
Total (agree to Schedule V, line 19, column 3)		254,394
Allocated from Management Company Legal Fees		9,784
Allocated from Management Company Professional Services		
Less: Non-Allowable Legal Fees		(92,397)
Total (agree to Schedule V, line 19, column 8)		171,781

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 - \$15,220

(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. \$ 58,552 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. \$ 391,483

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. \$ 215

(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.

HFS 3745 (N-4-99)

IL478-2471