

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

Address: 2600 N Annie Glidden DeKalb 60115
Number City Zip Code

County: DeKalb

Telephone Number: (815) 758-2477 Fax # (815) 217-0451

HFS ID Number:

Date of Initial License for Current Owners: 07/15/54

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

X

GOVERNMENTAL

State

X County

Other

In the event there are further questions about this report, please contact:

Name: Jeremy M. Brune, CPA Telephone Number: (779) 875 - 3979

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/25 to 12/31/25 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)

(Type or Print Name) Bart Becker

(Title) Administrator

(Signed)

05/28/26

(Date)

Paid Preparer

(Print Name and Title) Jeremy M. Brune, CPA CEO

(Firm Name & Address) Jeremy Brune & Associates, LLC 2508 Riverwalk Drive Plainfield, Illinois 60586

(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number

DeKalb County Rehab Nursing

#

0044321

Report Period Beginning:

01/01/25

Ending:

12/31/25

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	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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	4,741	4,490	14,728		11,772	3,556	2,238	41,525	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,741	4,490	14,728		11,772	3,556	2,238	41,525	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

59.88%

D. How many bed reserve days during this year were paid by the Department?

0

(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)

N/A

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

NO

X

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

03/09/00

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 certified beds.

number of certified beds

190

Medicare Intermediary

National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/25

Fiscal Year:

12/31/25

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

Facility Name & ID Number DeKalb County Rehab Nursing # 0044321 Report Period Beginning: 01/01/25 Ending: 12/31/25

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	1,237,633	64,322	28,680	1,330,635		1,330,635		1,330,635			1
2	Food Purchase		494,544		494,544		494,544	(1,227)	493,317			2
3	Housekeeping	393,951	52,227		446,178		446,178		446,178			3
4	Laundry	76,003	8,708	190,077	274,788		274,788		274,788			4
5	Heat and Other Utilities			436,047	436,047		436,047		436,047			5
6	Maintenance	133,147	59,187	232,374	424,708		424,708	9,286	433,994			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	1,840,734	678,988	887,178	3,406,900		3,406,900	8,059	3,414,959			8
	B. Health Care and Programs											
9	Medical Director			5,400	5,400		5,400		5,400			9
10	Nursing and Medical Records	7,257,865	338,017	64,225	7,660,107		7,660,107	(75)	7,660,032			10
10a	Therapy	206,893	8,779	602	216,274		216,274		216,274			10a
11	Activities	339,848	11,503	14,091	365,442		365,442		365,442			11
12	Social Services	175,107	2,372	639	178,118		178,118		178,118			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	7,979,713	360,671	84,957	8,425,341		8,425,341	(75)	8,425,266			16
	C. General Administration											
17	Administrative	150,683			150,683		150,683	83,247	233,930			17
18	Directors Fees											18
19	Professional Services			372,282	372,282		372,282	3,870	376,152			19
20	Dues, Fees, Subscriptions & Promotions			35,857	35,857		35,857	(18,635)	17,222			20
21	Clerical & General Office Expenses	575,775	52,282	862,949	1,491,006		1,491,006	(373,029)	1,117,977			21
22	Employee Benefits & Payroll Taxes			2,541,810	2,541,810		2,541,810		2,541,810			22
23	Inservice Training & Education			4,106	4,106		4,106		4,106			23
24	Travel and Seminar			3,856	3,856		3,856		3,856			24
25	Other Admin. Staff Transportation			1,702	1,702		1,702		1,702			25
26	Insurance-Prop.Liab.Malpractice			417,641	417,641		417,641	27,845	445,486			26
27	Other (specify):* See Supplemental							116,682	116,682			27
28	TOTAL General Administration	726,458	52,282	4,240,203	5,018,943		5,018,943	(160,020)	4,858,923			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,546,905	1,091,941	5,212,338	16,851,184		16,851,184	(152,036)	16,699,148			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.

DeKalb County Rehab & Nursing Center
Medicaid Cost Report
01/01/25 - 12/31/25

Page 3 Supplemental Schedule

Description	Salaries		Supplies		Other		Total	
Line 7 - Other General Services								
								-
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		-		-
Line 15 - Other Health Care Services								
								-
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		-		-
Line 27 - Other General Administration								
Alloc.DeKalb County (Emp. Benefits)						116,682		116,682
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		116,682		116,682

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			865,711	865,711		865,711	1,706	867,417			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			393,013	393,013		393,013	(134,412)	258,601			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,202	7,202		7,202		7,202			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			1,265,926	1,265,926		1,265,926	(132,706)	1,133,220			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		242,968	713,726	956,694		956,694		956,694			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			159,026	159,026		159,026		159,026			42
43	Other (specify):* See Supplemental			2,226	2,226		2,226	(2,226)				43
44	TOTAL Special Cost Centers		242,968	874,978	1,117,946		1,117,946	(2,226)	1,115,720			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,546,905	1,334,909	7,353,242	19,235,056		19,235,056	(286,968)	18,948,088			45

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

DeKalb County Rehab & Nursing Center
Medicaid Cost Report
01/01/25 - 12/31/25

Page 4 Supplemental Schedule

Description	Salaries		Supplies		Other		Total	
Line 36 - Other Capital Costs								
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		-		-
Line 43 - Other Special Cost Centers								
Community Relations						2,226		2,226
								-
								-
								-
								-
								-
Sub-Total		-		-		2,226		2,226

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,219)	02		4
5	Telephone, TV & Radio in Resident Rooms	(31,503)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(134,412)	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	(6,250)	21		18
19	Entertainment				19
20	Contributions	(18,635)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(613,748)	21		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 Supplemental Schedule	(19,874)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (832,141)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	545,173		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 545,173		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (286,968)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Credit Card Fees	(1,624)	21	4
5	Community Relations	(2,226)	43	5
6	Telephone Income	(1,522)	21	6
7	Postage Income	(2)	21	7
8	Jury Duty Reimbursement	(75)	10	8
9	Meal Income	(8)	2	9
10	Other Income	(484)	21	10
11	Rebates and Refunds	(15,639)	21	11
12	PY R&M Depreciation Expense	1,706	30	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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36				36
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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	(19,874)		49

Summary A

12/31/25

[illegible]

Summary B

Facility Name & ID Number

0044321

01/01/25

12/31/25

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

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	100.00%					

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	22	FICA	\$ 765,522	DeKalb County, Illinois	100.00%	\$ 765,522		1
2	V	22	IMRF	953,068	DeKalb County, Illinois	100.00%	953,068		2
3	V	22	Health Insurance	833,577	DeKalb County, Illinois	100.00%	833,577		3
4	V	22	Workers Comp Insurance	(64,363)	DeKalb County, Illinois	100.00%	(64,363)		4
5	V								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			\$ 2,487,804			\$ 2,487,804	\$ *	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.

☒ 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	100.00%	\$ 9,286	\$ 9,286	15
16	V	17	County Board Costs		DeKalb County, Illinois	100.00%	83,247	83,247	16
17	V	19	State's Attorney		DeKalb County, Illinois	100.00%	10,370	10,370	17
18	V	21	Dept. and Non-Dept. Costs		DeKalb County, Illinois	100.00%	297,743	297,743	18
19	V	26	Risk Management		DeKalb County, Illinois	100.00%	27,845	27,845	19
20	V	27	Employee Benefits		DeKalb County, Illinois	100.00%	116,682	116,682	20
21	V								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			\$			\$ 545,173	\$ * 545,173	39

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

Ownership Listing-1

ID# 0044321

01/01/25

12/31/25

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names

- Names of trust beneficiaries must be listed

Operator/Licensee

Building Co.

Co. /Home Office

Co. /Home Office

Names of trust beneficiaries must be listed.			Place of Residence		Ownership Percentage	Ownership Percentage	Ownership Percentage	
	First Name	M.I.	Last Name	City	State			
1	Tim		Bagby	Sycamore	IL	N/A	N/A	N/A
2	Clyde		Campbell	Dekalb	IL	N/A	N/A	N/A
3	Kim		Covert	Sycamore	IL	N/A	N/A	N/A
4	Mary		Cozad	Dekalb	IL	N/A	N/A	N/A
5	Rukisha		Crawford	Dekalb	IL	N/A	N/A	N/A
6	Patrick		Deutsch	Sycamore	IL	N/A	N/A	N/A
7	Meryl		Domina	Dekalb	IL	N/A	N/A	N/A
8	Laurie		Emmer	Sycamore	IL	N/A	N/A	N/A
9	John		Frieders	Sandwich	IL	N/A	N/A	N/A
10	Benjamin		Haier	Cortland	IL	N/A	N/A	N/A
11	Rhonda		Henke	Clare	IL	N/A	N/A	N/A
12	Laura		Hoffman	Dekalb	IL	N/A	N/A	N/A
13	Tim		Hughes	Kingston	IL	N/A	N/A	N/A
14	Kathy		Lampkins	Sycamore	IL	N/A	N/A	N/A
15	Jim		Luebke	Dekalb	IL	N/A	N/A	N/A
16	Elizabeth		Lundeen	Sycamore	IL	N/A	N/A	N/A
17	Terri		Mann-Lamb	Dekalb	IL	N/A	N/A	N/A
18	Joseph		Marcinkowski	Hinckley	IL	N/A	N/A	N/A
19	Michelle		Pickett	Dekalb	IL	N/A	N/A	N/A
20	Roy		Plote	Leland	IL	N/A	N/A	N/A
21	Chris		Porterfield	Dekalb	IL	N/A	N/A	N/A
22	Ellingsworth		Webb	Dekalb	IL	N/A	N/A	N/A
23	Suzanne		Fahnestock	Maple Park	IL	N/A	N/A	N/A
24	Rebecca		Johnson	Sandwich	IL	N/A	N/A	N/A
25								
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27								
28								
29								
30								
31								
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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									\$		1
2	N/A - County Owned										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number DeKalb County Rehab Nursing # 0044321 Report Period Beginning: 01/01/25 Ending: 12/31/25

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 East Sycamore Street
City / State / Zip Code Sycamore, Illinois 60178
Phone Number (815) 895 - 7189
Fax Number (815) 895 - 7187

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number DeKalb County Rehab Nursing # 0044321 Report Period Beginning: 01/01/25 Ending: 12/31/25

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 East Sycamore Street
City / State / Zip Code Sycamore, Illinois 60178
Phone Number (815) 895 - 7189
Fax Number (815) 895 - 7187

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Page 8A Supplemental			\$	\$		\$ 9,286	1
2	17	County Board Costs	Page 8A Supplemental						83,247	2
3	19	State's Attorney	Page 8A Supplemental						10,370	3
4	21	Dept. and Non-Dept. Costs	Page 8A Supplemental						297,743	4
5	26	Risk Management	Page 8A Supplemental						27,845	5
6	27	Employee Benefits	Page 8A Supplemental						116,682	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 545,173	25

DeKalb County Rehab & Nursing Center
Medicaid Cost Report
01/01/25 - 12/31/25

Page 8A: DeKalb County Allocation Calculations

[illegible]

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	IL Bonds - Series 2020		X	Facility Expansion Project	\$75,000.00	08/18/20	\$ 13,000,000	\$ 11,805,000	12/15/50	5.000%	\$ 393,013	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$75,000.00		\$ 13,000,000	\$ 11,805,000			\$ 393,013	9	
	B. Non-Facility Related*												
10												10	
11	Int. & Investment Income										(134,412)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (134,412)	14	
15	TOTALS (line 9+line14)						\$ 13,000,000	\$ 11,805,000			\$ 258,601	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 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.)		\$		2	
3. Under or (over) accrual (line 2 minus line 1).		\$		3	
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$		7	
Assessed Value from Real Estate Tax Bill:		2024		8	
Real Estate Tax Bill for Calendar Year:		2020		9	
		2021		10	
		2022		11	
		2023		12	
		2024		13	
County Facility - Exempt from Real Estate Taxes				14	FOR BHF USE ONLY
				14	FROM R. E. TAX STATEMENT FOR 2024 \$
				15	PLUS APPEAL COST FROM LINE 5 \$
				16	LESS REFUND FROM LINE 6 \$
				17	AMOUNT TO USE FOR RATE CALCULATION \$

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DeKalb County Rehab Nursing COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0044321

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA

TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(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.		\$	\$
2.	N/A	\$	\$
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 X 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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 81,992

B. General Construction Type: Exterior Brick & VinylFrame Wood & MetalNumber 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).

N/A

F. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

K. 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:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number DeKalb County Rehab Nursing

0044321

Report Period Beginning:

01/01/25

Ending:

12/31/25

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	\$ 12,066,769	\$ 422,893		\$ 422,893	\$	11,673,556	4
5			2022	2022	14,447,871	361,197		361,197		1,775,400	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	12,293					12,293	9
10	Various			2000	158,269	360		360		158,269	10
11	Various			2001	85,537	562		562		85,434	11
12	Various			2002	10,421	98		98		10,316	12
13	Various			2003	11,355					11,355	13
14	Various			2004	35,633					35,633	14
15	Various			2005	346,970	1,125		1,125		346,970	15
16	Various			2006	23,791	61		61		23,791	16
17	Various			2007	4,847					4,847	17
18	Various			2008	57,079	485		485		56,696	18
19	Various			2009	42,485	390		390		41,185	19
20	Various			2010	5,568	278		278		4,246	20
21	Various			2011	5,785					5,785	21
22	Various			2012	147,158					147,158	22
23	Various			2013	40,638	1,113		1,113		38,341	23
24	Various			2014	40,409	2,195		2,195		38,059	24
25	Various			2015	37,623	1,791		1,791		31,696	25
26	Various			2016	157,492	14,769		14,769		151,689	26
27	Various			2017	14,350	1,435		1,435		12,613	27
28	Various			2018	29,211	2,321		2,321		16,531	28
29	Various			2019	28,973	2,897		2,897		18,832	29
30	Various			2020	18,100	1,144		1,144		9,416	30
31				2021	59,991	8,835		8,835		40,998	31
32											32
33											33
34											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

XI. OWNERSHIP COSTS (continued)

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

1		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	R&M - Generator Fuel Leak	2022	\$ 5,900	\$		\$ 1,180	\$ 1,180	\$ 4,130	37
38	R&M - Hot Water Circulating Pump	2022	2,628			526	526	1,841	38
39	HVAC Upgrade	2025	15,700	131		131		131	39
40	HVAC Upgrade - Evaporator Unit	2025	35,610	594		594		594	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 27,948,458	\$ 824,674		\$ 826,380	\$ 1,706	\$ 14,757,807	70

**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	\$2,181,927	\$33,101	\$33,101	\$		\$2,080,170	71
72	Current Year Purchases	65,927	7,936	7,936			7,936	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,247,854	\$41,037	\$41,037	\$		\$2,088,106	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	GMC Sierra With Plow	2015	\$32,974	\$	\$	\$		\$32,974	76
77										77
78										78
79										79
80	TOTALS			\$32,974	\$	\$	\$		\$32,974	80

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)	\$30,229,286	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$865,711	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$867,417	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$1,706	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$16,878,887	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

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	N/A							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
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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: \$7,202
- Description:
- See Supplemental Schedule
- (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			\$	\$	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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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.

DeKalb County Rehab & Nursing Center
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Page 14 Supplemental Schedule

Description		Amount		Total
Building Rental				
				-
N/A				-
		-		-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		-	-	
Equipment Rental				
GFC Leasing - Copier		7,202		7,202
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		7,202	7,202	

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

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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 - 03	hrs	\$		\$ 181,430	\$		\$ 181,430	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			88,888			88,888	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			227,877			227,877	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				166,386		166,386	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					76,582		76,582	12
13	Other (specify): See Supplemental	39 - 03				215,531			215,531	13
14	TOTAL			\$		\$ 713,726	\$ 242,968		\$ 956,694	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.

DeKalb County Rehab & Nursing Center
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Page 16 Supplemental Schedule

[illegible]

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	\$ 5,023,915	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,082,012)	3,202,501		3
4	Supply Inventory (priced at FIFO - Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,226		6
7	Other Prepaid Expenses	211,899		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,532,541	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	27,939,930		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,280,828		16
17	Accumulated Depreciation (book methods)	(16,872,916)		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 (specify):			22
23	Other(specify): See Supplemental Schedule	519,935		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,867,777	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 22,400,318	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,288,974	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	968,513		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			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,306,089		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,563,576	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	11,805,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,805,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,368,576	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,031,742	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 22,400,318	\$	48

*(See instructions.)

DeKalb County Rehab & Nursing Center
Medicaid Cost Report
01/01/25 - 12/31/25

Page 17 Supplemental Schedule

Description		Operating		Building		Total
Line 9 - Other Current Assets						
						-
						-
						-
						-
						-
Sub-Total		-		-		-
Line 23 - Long Term Assets						
Construction in Progress		7,951				7,951
Senior Living Development Costs		3,992				3,992
Intergovernmental Receivable		12,919				12,919
Deferred Pension and IMRF Balance		495,073				495,073
						-
Sub-Total		519,935		-		519,935
Line 36 - Other Current Liability						
Unamortized Bond Premiums		1,306,089				1,306,089
						-
						-
						-
						-
Sub-Total		1,306,089		-		1,306,089
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,882,650	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,882,650	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	149,092	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)	\$ 149,092	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)	\$ 7,031,742	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number DeKalb County Rehab Nursing

0044321

Report Period Beginning:

01/01/25

Ending:

12/31/25

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	\$ 16,705,798	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,705,798	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	254,035	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 254,035	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,219	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,219	23
	D. Non-Operating Revenue		
24	Contributions	110,818	24
25	Interest and Other Investment Income***	134,412	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 245,230	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	361,006	28
28a	Intergovernment Transfers - DeKalb County	1,816,860	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,177,866	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,384,148	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,406,900	31
32	Health Care	8,425,341	32
33	General Administration	5,018,943	33
	B. Capital Expense		
34	Ownership	1,265,926	34
	C. Ancillary Expense		
35	Special Cost Centers	958,920	35
36	Provider Participation Fee	159,026	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,235,056	40
41	Income before Income Taxes (line 30 minus line 40)**	149,092	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 149,092	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,754,969	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,662,056	45
46	MMAI-Medicaid is the Primary Payer	5,451,841	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	4,640,710	48
49	Medicare Part A	2,068,611	49
50	Other-(specify) Insurance	839,620	50
51	Other-(specify) Hospice	287,991	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 16,705,798	56

DeKalb County Rehab & Nursing Center
Medicaid Cost Report
01/01/25 - 12/31/25

Page 19 Supplemental Schedule

[illegible]

Facility Name & ID Number DeKalb County Rehab Nursing# 0044321

Report Period Beginning:

01/01/25

Ending:

12/31/25

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	2,032	2,330	\$ 141,058	\$ 60.54	1
2	Assistant Director of Nursing	1,984	2,205	116,150	52.68	2
3	Registered Nurses	40,740	43,717	2,342,783	53.59	3
4	Licensed Practical Nurses	14,182	15,020	642,041	42.75	4
5	CNAs & Orderlies	109,156	111,324	3,270,362	29.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,527	5,989	206,893	34.55	8
9	Activity Director	1,921	2,112	60,015	28.42	9
10	Activity Assistants	13,123	13,767	279,831	20.33	10
11	Social Service Workers	5,728	6,374	175,107	27.47	11
12	Dietician					12
13	Food Service Supervisor	5,564	6,177	171,433	27.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	49,017	50,412	1,066,199	21.15	15
16	Dishwashers					16
17	Maintenance Workers	4,205	4,612	133,147	28.87	17
18	Housekeepers	18,387	19,937	393,951	19.76	18
19	Laundry	3,277	3,455	76,003	22.00	19
20	Administrator	1,950	2,080	150,683	72.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,875	12,856	352,692	27.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Suppl.</u>	24,487	27,342	968,557	35.42	33
34	TOTAL (lines 1 - 33)	313,155	329,709	\$ 10,546,905 *	\$ 31.99	34

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		\$ 26,250	01 - 03	35
36	Medical Director		5,400	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,466	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,041	11 - 03	44
45	Social Service Consultant		639	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 44,796		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 35,890	10 - 03	50
51	Licensed Practical Nurses		1,168	10 - 03	51
52	Certified Nurse Assistants/Aides		16,358	10 - 03	52
53	TOTAL (lines 50 - 52)		\$ 53,416		53

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

** See instructions.

DeKalb County Rehab & Nursing Center
Medicaid Cost Report
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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Care Plan Coordinator	10	4,136	4,361	236,934	54.33		
Director of Special Care Unit	10	1,765	2,051	94,772	46.21		
Medicare Case Managers	10	1,921	2,104	86,236	40.99		
Nursing Secretary	10	1,916	2,368	67,602	28.55		
Scheduling Coordinators	10	2,056	2,256	50,353	22.32		
Unit Assistant	10	5,007	5,218	100,075	19.18		
Ward Secretary	10	3,848	4,588	121,311	26.44		
Corporate Compliance Officer	21	1,962	2,185	101,772	46.58		
Education Coordinator	21	1,876	2,211	109,502	49.53		
					-		
					-		
					-		
					-		
					-		
					-		
Total		24,487	27,342	968,557			

Contracted Services

Total			-	-

STATE OF ILLINOIS

Facility Name & ID NumberDeKalb County Rehab Nursing# 0044321Report Period Beginning:01/01/25Ending:12/31/25Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Bart Becker

Administrator

0

\$ 150,683

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

(List each licensed administrator separately.)

\$ 150,683

B. Administrative - Other

Description

Amount

\$

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

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Carden & Tracy, LLC

Legal

\$ 60,731

Laner Mucher, LTD

Legal

6,500

Polsinelli, PC

Legal

6,925

Roth Legal, LLC

Legal

5,634

Ekl, Williams & Provenzale, LLC

Legal

57,302

Jordan Healthcare Group, LLC

Operations Consultant

223,060

Jeremy Brune & Assoc., LLC

Cost Reports

8,062

Activiated Insights

Cust. Serv. Consultant

4,068

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

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

\$ 372,282

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ (64,363)

Unemployment Compensation Insurance

25,568

FICA Taxes

765,522

Employee Health Insurance

833,577

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

953,068

Uniforms

18,255

Life Insurance

6,026

Medical Expense

3,162

Other

995

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

\$ 2,541,810

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

1,478

Health Care Worker Background Check

6,119

(Indicate # of checks performed)

Patient Background Checks

Association Dues (total from pg 22, #4)

4,088

Dues and Subscriptions

2,617

Licenses

930

Contributions

18,635

Less: Public Relations Expense

()

PAC and Lobbying payments

()

All non-allowable advertising

(18,635)

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

\$ 17,222

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

3,856

Entertainment Expense

()

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

TOTAL

\$ 3,856

* Attach copy of IMRF notifications

**See instructions.

DeKalb County Rehab & Nursing Center
Medicaid Cost Report
01/01/25 - 12/31/25

Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date	Amount	Non-Allowable	Allowable
Carden & Tracy, LLC	Resident Related Matters	03/19/25	5,289		5,289
Carden & Tracy, LLC	Resident Related Matters	03/19/25	4,100		4,100
Carden & Tracy, LLC	Resident Related Matters	04/16/25	2,855		2,855
Carden & Tracy, LLC	Resident Related Matters	04/16/25	1,722		1,722
Carden & Tracy, LLC	Resident Related Matters	05/21/25	8,331		8,331
Carden & Tracy, LLC	Resident Related Matters	05/21/25	11,091		11,091
Carden & Tracy, LLC	Resident Related Matters	06/18/25	4,328		4,328
Carden & Tracy, LLC	Resident Related Matters	06/18/25	1,292		1,292
Carden & Tracy, LLC	Resident Related Matters	07/16/25	4,207		4,207
Carden & Tracy, LLC	Resident Related Matters	08/20/25	1,025		1,025
Carden & Tracy, LLC	Resident Related Matters	09/17/25	1,727		1,727
Carden & Tracy, LLC	Resident Related Matters	09/17/25	21		21
Carden & Tracy, LLC	Resident Related Matters	10/15/25	7,311		7,311
Carden & Tracy, LLC	Resident Related Matters	10/15/25	286		286
Carden & Tracy, LLC	Resident Related Matters	11/19/25	5,121		5,121
Carden & Tracy, LLC	Resident Related Matters	12/17/25	1,739		1,739
Carden & Tracy, LLC	Resident Related Matters	12/31/25	144		144
Carden & Tracy, LLC	Resident Related Matters	12/31/25	144		144
Ekl, Williams & Provenzale, LLC	Resident Related Matters	05/21/25	5,690		
Ekl, Williams & Provenzale, LLC	Resident Related Matters	09/17/25	9,210		
Ekl, Williams & Provenzale, LLC	Resident Related Matters	12/19/25	27,507		
Ekl, Williams & Provenzale, LLC	Resident Related Matters	12/19/25	14,895		
Laner Munch, Ltd.	Retainer (Adj. Out)	02/19/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	02/19/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	04/16/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	06/18/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	06/18/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	07/16/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	08/20/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	08/20/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	10/15/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	11/19/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	12/17/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	12/17/25	500	500	-
Laner Munch, Ltd.	Retainer (Adj. Out)	12/31/25	500	500	-
Polsinelli, PC	Regulatory Matters	03/19/25	263		263
Polsinelli, PC	Regulatory Matters	05/21/25	175		175
Polsinelli, PC	Regulatory Matters	06/18/25	412		412
Polsinelli, PC	Regulatory Matters	08/20/25	861		861
Polsinelli, PC	Regulatory Matters	09/17/25	2,857		2,857
Polsinelli, PC	Regulatory Matters	12/17/25	1,538		1,538
Polsinelli, PC	Regulatory Matters	12/31/25	820		820
					-
Total			131,458	6,500	67,656

Facility Name & ID Number DeKalb County Rehab Nursing

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|--------------------------|--------------------|
| <u>IL AGING SERVICES</u> | <u>4,088</u> |
| | |
| | |
| | <u>4,088</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|--------------------------|-------|
| <u>IL AGING SERVICES</u> | |
| | |
| | |
| | |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|--------------------------|--------------------|
| <u>IL AGING SERVICES</u> | <u>4,088</u> |
| | |
| | |
| | <u>4,088</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ Line 10 - 02
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 159,026
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) 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. \$ 1,219
- (12) 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? Ln. 14
- d. Have vehicle usage logs been maintained? Yes
- 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
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sikich, LLP
- (14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes
- (15) 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.