

Facility Name & ID Number Du Page Convalescent Center# 0008201 Report Period Beginning: Dec. 1, 2006 Ending: Nov. 30, 2007

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 bedsN/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>508</u>	Skilled (SNF)	<u>508</u>	<u>185,420</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>508</u>	TOTALS	<u>508</u>	<u>185,420</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>90,972</u>	<u>18,142</u>	<u>10,094</u>	<u>119,208</u>	8
9	SNF/PED					9
10	ICF	<u>1,094</u>	<u>0</u>	<u>0</u>	<u>1,094</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>92,066</u>	<u>18,142</u>	<u>10,094</u>	<u>120,302</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.88%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Empl. Meals, Empl. Pharmacy & Therapy, County Laundry & PharmacyF. 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

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 1/01/1935

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 50 and days of care provided 9,195Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: YE 11/30/07 Fiscal Year: YE 11/30/07

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2006 Ending: Nov. 30, 2007

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	1,504,634	122,424	2,694	1,629,752		1,629,752	(519,083)	1,110,669			1
2	Food Purchase		1,193,581		1,193,581		1,193,581	(380,161)	813,420			2
3	Housekeeping	1,383,975	104,620	57,760	1,546,355		1,546,355	(128,253)	1,418,102			3
4	Laundry	305,453	108,111	1,301	414,865		414,865	(1,243)	413,622			4
5	Heat and Other Utilities			1,458,122	1,458,122		1,458,122		1,458,122			5
6	Maintenance			645,615	645,615		645,615	14,198	659,813			6
7	Other (specify):*											7
8	TOTAL General Services	3,194,062	1,528,736	2,165,492	6,888,290		6,888,290	(1,014,542)	5,873,748			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	11,268,092	426,437	1,063,400	12,757,929	(924,864)	11,833,065		11,833,065			10
10a	Therapy	559,818	21,949	(3,002)	578,765	924,864	1,503,629		1,503,629			10a
11	Activities	453,633	11,401	50	465,084		465,084		465,084			11
12	Social Services	262,715	853	3,570	267,138		267,138		267,138			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	12,544,258	460,640	1,064,018	14,068,916		14,068,916		14,068,916			16
	C. General Administration											
17	Administrative	197,961		587,416	785,377		785,377	97,787	883,164			17
18	Directors Fees											18
19	Professional Services			97,980	97,980		97,980	9,775	107,755			19
20	Dues, Fees, Subscriptions & Promotions			73,492	73,492		73,492	(34,936)	38,556			20
21	Clerical & General Office Expenses	865,648	34,660	63,954	964,262		964,262	(114,678)	849,584			21
22	Employee Benefits & Payroll Taxes			5,201,670	5,201,670		5,201,670	4,444	5,206,114			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,040	10,040		10,040		10,040			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			287,874	287,874		287,874		287,874			26
27	Other (specify):*											27
28	TOTAL General Administration	1,063,609	34,660	6,322,426	7,420,695		7,420,695	(37,608)	7,383,087			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	16,801,929	2,024,036	9,551,936	28,377,901		28,377,901	(1,052,150)	27,325,751			29

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

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

Facility Name & ID Number Du Page Convalescent Center

#0008201

Report Period Beginning: Dec. 1, 2006 Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			1,413,511	1,413,511		1,413,511	1,864	1,415,375			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			128,534	128,534		128,534		128,534			35
36	Other (specify):*											36
37	TOTAL Ownership			1,542,045	1,542,045		1,542,045	1,864	1,543,909			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	386,086	2,897,381	77,665	3,361,132		3,361,132		3,361,132			39
40	Barber and Beauty Shops	55,113			55,113		55,113		55,113			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							278,130	278,130			42
43	Other (specify):* Cnty NH MA Tax			6,146,323	6,146,323		6,146,323		6,146,323			43
44	TOTAL Special Cost Centers	441,199	2,897,381	6,223,988	9,562,568		9,562,568	278,130	9,840,698			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	17,243,128	4,921,417	17,317,969	39,482,514		39,482,514	(772,156)	38,710,358			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(107,300)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,243)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,259)	21		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (111,802)		\$	30

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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (111,802)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule <u>Therapy</u>	X		924,864	10	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 924,864		47

BHF USE ONLY					
48		49		50	51
					52

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: Dec. 1, 2006

Ending: Nov. 30, 2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Cafeteria Income - Other Dietary Costs	\$ (92,987)	1	1
2	Cafeteria Income - Food	(68,101)	2	2
3	421 Cafeteria Income - Other Dietary Costs	(426,096)	1	3
4	421 Cafeteria Income - Food	(312,060)	2	4
5	Other Misc Revenues	(111,419)	21	5
6	Overpayments and Refunds expense	(34,936)	20	6
7	West Campus Cleaning Revenue	(128,253)	3	7
8	Provider Participation Fee	278,130	42	8
9	Indirect FICA cost adjustment	4,444	22	9
10	Indirect Repairs expense adjustment	121,498	6	10
11	County Audit Expense	9,775	19	11
12	County Board Expense	22,616	17	12
13	Loss on Disposal of Moveable Equipment	1,864	30	13
14	County Treasurer Expense	67,842	17	14
15	County Clerk Expense	7,329	17	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(660,354)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center

0008201

Report Period Beginning:

Dec. 1, 2006

Ending:

Nov. 30, 2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(519,083)	0	0	0	0	0	0	0	0	0	0	(519,083)	1
2	Food Purchase	(380,161)	0	0	0	0	0	0	0	0	0	0	(380,161)	2
3	Housekeeping	(128,253)	0	0	0	0	0	0	0	0	0	0	(128,253)	3
4	Laundry	(1,243)	0	0	0	0	0	0	0	0	0	0	(1,243)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	14,198	0	0	0	0	0	0	0	0	0	0	14,198	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,014,542)	0	0	0	0	0	0	0	0	0	0	(1,014,542)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	97,787	0	0	0	0	0	0	0	0	0	0	97,787	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	9,775	0	0	0	0	0	0	0	0	0	0	9,775	19
20	Fees, Subscriptions & Promotions	(34,936)	0	0	0	0	0	0	0	0	0	0	(34,936)	20
21	Clerical & General Office Expenses	(114,678)	0	0	0	0	0	0	0	0	0	0	(114,678)	21
22	Employee Benefits & Payroll Taxes	4,444	0	0	0	0	0	0	0	0	0	0	4,444	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(37,608)	0	0	0	0	0	0	0	0	0	0	(37,608)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,052,150)	0	0	0	0	0	0	0	0	0	0	(1,052,150)	29

STATE OF ILLINOIS

Facility Name & ID Number Du Page Convalescent Center

0008201 Report Period Beginning:

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Summary B
Nov. 30, 2007

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,864	0	0	0	0	0	0	0	0	0	0	1,864	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,864	0	1,864	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	278,130	0	0	0	0	0	0	0	0	0	0	278,130	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	278,130	0	278,130	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(772,156)	0	(772,156)	45									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							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		\$			\$	\$ *	14

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

Facility Name & ID Number

Du Page Convalescent Center

#

0008201

Report Period Beginning:

Dec. 1, 2006

Ending:

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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	NONE								\$	1
2										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 Du Page Convalescent Center

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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 Du Page County Government
 Street Address 421 N. County Farm Road (Finance Dept)
 City / State / Zip Code Wheaton, Illinois 60187
 Phone Number (630) 407-6121 (Lynn Wood)
 Fax Number (630) 407-6102

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	22	LM.R.F. & Social Security	Direct Cost	14,731,777		\$ 14,731,777	\$ 0	2,793,318	\$ 2,793,318	1
2	19	Finance & AP	# of A/P Claims	41,227	166	402,823	244,567	4,122	40,275	2
3	19	County Audit	% of Time Spent	244,388	11	244,388	0	9,775	9,775	3
4	19	County Auditor	# of A/P Claims	40,574	165	54,591	33,373	4,122	5,546	4
5	19	General Acctg & Budget	% of All Depts	1,633,956	53	1,633,956	902,276	30,829	30,829	5
6	21	Mail Delivery	Wtd Avg # of Del	302,000	44	302,000	169,017	7,036	7,036	6
7	22	Workers Comp Expense	Dir Cost & FTEs/Clms	2,319,656	2983	2,319,656	0	281,077	281,077	7
8	26	Property Insurance	Building Value %	344,964		344,964	0	29,464	29,464	8
9	26	Gen/Prof Liability Insurance	Direct Cost/FTE/Hd Ct	1,154,414	2440	1,154,414	0	232,757	232,757	9
10	26	Surety Bond & Premiums	Direct Cost/FTE	41,706	2440	41,706	0	8,008	8,008	10
11	22	Unemployment Comp Ins	Direct Cost/FTE	293,578	2983	293,578	0	41,836	41,836	11
12	26	Service retention Fee	# of Ins Claims	188	21	103,662	0	32	17,645	12
13	5	Utilities	Square Footage	4,156,092	50	4,156,092	0	49,491	49,491	13
14	5	Space Allocation	Square Footage	2,431,599	52	2,431,599	1,116,714	404,855	404,855	14
15	5	Power Plant cost	Square Footage	3,707,252	48	3,707,252	1,702,558	211,860	211,860	15
16	17	Security	Square Footage	1,029,285	52	1,029,285	648,715	174,105	174,105	16
17	6	Building Maintenance	Direct Cost	2,382,988		2,382,988	1,094,389	639,210	639,210	17
18	6	Repair & Maint cost	Square Footage	885,760	52	885,760	426,163	121,498	121,498	18
19	35	Rental of Equipment	Direct Cost	29,431	0	29,431	0	2,071	2,071	19
20	6	Repair & Maint of Equip	Direct Cost	38,460		38,460	0	6,405	6,405	20
21	17	Personnel Costs & Benfts Adm	FTEs	4,510	60	1,687,392	826,764	838	313,561	21
22	17	Purchasing Costs	# of Purchase Orders	1,432	99	812,348	456,461	176	99,751	22
23	17	County Board	Comm Assignmnts	905,474	49	905,474	905,474	22,616	22,616	23
24	17	County Treasurer & Clerk	# of checks & rel orders	75,171	49	75,171	75,171	75,171	75,171	24
25	TOTALS					\$ 39,768,767	\$ 8,601,642		\$ 5,618,160	25

Facility Name & ID Number

Du Page Convalescent Center

0008201

Report Period Beginning:

Dec. 1, 2006 Ending:

Nov. 30, 2007

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Du Page Convalescent Center COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0008201

CONTACT PERSON REGARDING THIS REPORT Patrick Szajkovic

TELEPHONE (847) 259-7373, Ext. 111 FAX #: (847) 259-9869

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Du Page Convalescent Center

0008201 Report Period Beginning:

Dec. 1, 2006 Ending: Nov. 30, 2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 257,371 B. General Construction Type: Exterior Masonry Reinf Concr Frame Steel Number of Stories 5

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).

Du Page County Government (Parent Org.) offices and buildings are next to and across street from Du Page Convalescent Center.

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: N/A
(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	<u>Facility Buildings</u>	<u>400,000</u>	<u>1947</u>	<u>\$ 794,360</u>	1
2					2
3	TOTALS	400,000		\$ 794,360	3

Facility Name & ID Number Du Page Convalescent Center

0008201

Report Period Beginning:

Dec. 1, 2006 Ending: Nov. 30, 2007

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	288		1947	1947	\$ 70,858		30	\$		\$ 70,858	4
5	104			1978	4,456,548	148552	30	148,552		4,394,652	5
6	16			1979	1,750,524	58351	30	58,351		1,643,549	6
7				1983	1,172,064	34472	34	34,472		847,449	7
8	100			1993	6,516,821	233928	Various	233,928		3,569,237	8
	Improvement Type**										
9		Mech room renovation & heat exchangers		1976	44,372		20			44,372	9
10		Alarm equip doors & other, Project 181		1977	8,545		20			8,545	10
11		Cyclone dust collector		1978	12,188		20			12,188	11
12		Flagpole		1979	844		20			844	12
13		Kitchen floor / Ground north remodel		1981	212,304		20			212,304	13
14		South Bldg renovation - Phase III (Per 1989 Adj)		1983	3,871,516		20			3,871,516	14
15		South Bldg renovation - Phase III Architect fees		1983	262,953		20			262,953	15
16		Laundry, 3-Center & Nurse station remodel		1985	91,792		15/20			91,792	16
17		Tubs & Parking lot projects		1989	199,883	9,995	20	9,995		179,065	17
18		Oxygen Manifold - North Bldg		1990	5,423	272	20	272		4,588	18
19		Ground North & Hydrotherapy remodel		1991	331,512	11,464	15/20/25	11,464		286,500	19
20		Window replacement, 3-Center & Nurse station remodel		1992	604,207	32,536	10/15/20/25	32,536		510,148	20
21		Laundry water heater & softners, asphalt rep & landscape		1993	588,826	22,356	10/12/15/20	22,356		455,966	21
22		ADA & Elevator upgrades, Nurse station remodel & misc		1994	105,577	4,131	5/10/15/20	4,131		83,205	22
23		Sewer Ejector pumps & Carpet replacement		1995	31,457		5/10			31,457	23
24		Carpet replace in Recreation & Volunteer areas & misc		1996	7,963		5			7,963	24
25		Chilled water bridges, Liquid oxygen, Lights refit & Elevator		1997	320,587	16,114	5/10/20	16,114		193,716	25
26		Elevator Pit ladders & automatic entrance doors		1998	10,922	950	10/20	950		8,803	26
27		Lobby remodel, Carpet, Elevator safety system & HVAC		1999	701,043	56,997	5/10/20	56,997		555,651	27
28		Tubs, Reception, Laundry, Kitchen Elev, HVAC & access eqp		2000	848,131	69,537	5/10/15/20	69,537		589,542	28
29		Tub room remodel, Life safety system, Elev & Liq Oxygen eqp		2001	473,208	47,321	10	47,321		285,084	29
30		Carpeting, incl North Day Room		2002	8,582	924	5	924		8,582	30
31		Roof rehab, Card readers & Kitchen renovation		2002	219,254	21,926	10	21,926		113,387	31
32		Fire Alarm Dampers, Fire System & Constructn Admin		2002	1,515,449	151,545	10	151,545		757,760	32
33		Director Signage		2002	65,448	3,273	20	3,273		16,635	33
34		HVAC Modifications		2002	102,341	6,823	15	6,823		34,114	34
35		Curtain Wall Installation		2003	13,140	876	15	876		3,869	35
36		Carpet Installation		2003	1,148	230	5	230		1,110	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 Du Page Convalescent Center

0008201

Report Period Beginning:

Dec. 1, 2006 Ending: Nov. 30, 2007

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	Fencing - Wrought Iron	2003	\$ 21,810	\$ 873	25	\$ 873	\$	\$ 4,217	37
38	Curtain Wall Project	2003	338,936	33,894	10	33,894		138,399	38
39	Alarm System Prof Fees	2003	1,000	200	5	200		817	39
40	Fire Alarm System Replacement	2004	165,176	16,517	10	16,517		59,188	40
41	Hi-Res LW Light Camera	2004	2,768	554	5	554		1,753	41
42	Rekey Main Entrance & Door Contact Installation	2004	1,733	347	5	347		1,271	42
43	Pharmacy Storage Remodeling	2004	2,050	205	10	205		752	43
44	Reconfigure Front	2005	6,599	660	10	660		1,925	44
45	Commercial Carpet	2005	4,357	436	10	436		1,271	45
46	Air Handler CC	2005	75,447	7,545	10	7,545		19,491	46
47	New Door	2005	3,295	659	5	659		1,648	47
48	Wireless Exterior Gate	2005	12,010	2,402	5	2,402		5,605	48
49	Roof Top HVAC in Residents Dining Rm	2005	7,235	724	10	724		1,568	49
50	Floor Preparation	2005	721	72	10	72		198	50
51	North Entrance Badge Reader	2005	1,712	342	5	342		913	51
52	Wanderer System	2005	2,970	594	5	594		1,436	52
53	Relocate Card Reader - Door 4, Ground Floor	2005	2,704	541	5	541		1,217	53
54	Asst Administrators Office Carpet	2005	1,068	214	5	214		481	54
55	Fiber /PBX FON System	2005	2,842	569	5	569		1,137	55
56	Alarm Installation	2005	2,475	247	10	247		495	56
57	Door Repairs - 2 items	2005	8,463	1,692	5	1,692		3,385	57
58	Patch & Repair	2005	2,902	581	5	581		1,161	58
59	Fire Pump and Installation	2005	58,432	5,843	10	5,843		11,686	59
60	Steel Frame and Door	2006	2,136	427	5	427		641	60
61	Sidewalk Installation	2006	4,111	411	10	411		582	61
62	Laundry Room Lighting	2006	2,790	559	5	559		698	62
63	Locksmith - Lock Rekeyings	2006	3,109	621	5	621		725	63
64	Laundry Room Lighting	2006	2,557	511	5	511		554	64
65	Parking Lot Painting	2006	291	58	5	58		63	65
66	HVAC Modifications	2006	1,802,424	90,121	20	90,121		90,121	66
67	Laundry Room Renovation	2006	701,152	70,115	10	70,115		70,115	67
68	Fire Pump Installation	2006	135,000	13,500	10	13,500		13,500	68
69	Unlocated - Depr Reconcile adj to TB / Accum depr rounding			(3,884)		(3,884)		(7)	69
70	TOTAL (lines 4 thru 69)		\$ 28,005,705	\$ 1,180,723		\$ 1,180,723	\$	\$ 19,594,410	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 2,454,608	\$ 221,262	\$ 221,262	\$	5-15	\$ 1,965,611	71
72	Current Year Purchases	49,392	7,118	7,118		5-12	7,118	72
73	Fully Depreciated Assets	2,090,052					2,090,052	73
74	CY Deletions	(64,763)		1,864	1,864	12-15	(64,763)	74
75	TOTALS	\$ 4,529,289	\$ 228,380	\$ 230,244	\$ 1,864		\$ 3,998,018	75

D. Vehicle Depreciation (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	Snowplow & Maint/02 Van	Various/97 White Ford Van	Various/02	\$ 182,531	\$	\$	\$	3/4/10	\$ 182,531	76
77	Grounds Maintenance	John Deere Tractor	1999	12,685	1,268	1,268		10	11,099	77
78	Maint & Transport	Ford A-10 Van	2000	38,971				4	38,971	78
79	Maint & Transport	Window Van - 2001	2001	31,396	3,140	3,140		10	18,838	79
80	TOTALS			\$ 265,583	\$ 4,408	\$ 4,408	\$		\$ 251,439	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 33,594,937	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,413,511	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,415,375	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,864	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 23,843,867	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	Misc CIP	\$ 101,629	92
93			93
94			94
95		\$ 101,629	95

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

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

Facility Name & ID Number Du Page Convalescent Center

0008201

Report Period Beginning: Dec. 1, 2006

Ending: Nov. 30, 2007

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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 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: \$ 128,534 Description: Facility Medical and Office Equipment

(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

* 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 8	4180 hrs	149,166				4,180	149,166	4
5	Physician Care	Ln 10, Col 8	visits		6,370	32,500		6,370	32,500	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 8	74129 # of prescripts	386,086			2,832,643	74,129	3,218,729	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 535,252	6,370	\$ 32,500	\$ 2,832,643	84,679	\$ 3,400,395	14

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

Facility Name & ID Number Du Page Convalescent Center# 0008201Report Period Beginning: Dec. 1, 2006

Ending:

Nov. 30, 2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Nov. 30, 2007 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,772,471	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>500,000</u>)	5,311,783		3
4	Supply Inventory (priced at <u>Cost</u>)	334,727		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,418,981	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	784,360		13
14	Buildings, at Historical Cost	28,005,705		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,477,557		16
17	Accumulated Depreciation (book methods)	(23,843,867)		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 <u>CIP</u>)	101,628		22
23	Other(specify): <u>Leased Equip</u>	317,315		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,842,698	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,261,679	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,860,046	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,547,526		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	<u>Other Misc Accrued Liab</u>	438,948		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,846,520	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Accrued Comp</u>	877,633		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 877,633	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,724,153	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,537,526	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,261,679	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,212,253	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,212,253	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(3,270,508)	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)	\$ (3,270,508)	17
B. Transfers (Itemize):			
18	Capital Contributions - Total	2,595,781	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 2,595,781	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 12,537,526	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Du Page Convalescent Center# 0008201Report Period Beginning: Dec. 1, 2006Ending: Nov. 30, 2007**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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 29,866,160	1
2	Discounts and Allowances for all Levels	(4,088,422)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 25,777,738	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,672,149	6
7	Oxygen	(51,700)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,620,449	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	2,000,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	15,165	13
14	Non-Patient Meals	899,244	14
15	Telephone, Television and Radio	107,300	15
16	Rental of Facility Space		16
17	Sale of Drugs	3,480,663	17
18	Sale of Supplies to Non-Patients	111,419	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,243	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,615,034	23
D. Non-Operating Revenue			
24	Contributions	28,008	24
25	Interest and Other Investment Income***	44,388	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 72,396	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>West Campus Cleaning Revenue</u>	128,253	28
28a	<u>Misc. Other Losses</u>	(1,864)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 126,389	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 36,212,006	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	6,888,290	31
32	Health Care	14,068,916	32
33	General Administration	7,420,695	33
B. Capital Expense			
34	Ownership	1,542,045	34
C. Ancillary Expense			
35	Special Cost Centers	9,562,568	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 39,482,514	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,270,508)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,270,508)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.

Facility Name & ID Number Du Page Convalescent Center

0008201

Report Period Beginning: Dec. 1, 2006

Ending:

Nov. 30, 2007

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	1,831	2,165	\$ 116,998	\$ 54.04	1
2	Assistant Director of Nursing	3,556	4,329	171,028	39.51	2
3	Registered Nurses	108,722	123,860	3,975,436	32.10	3
4	Licensed Practical Nurses	35,099	39,306	997,689	25.38	4
5	CNAs & Orderlies	319,571	359,506	5,417,391	15.07	5
6	CNA Trainees					6
7	Licensed Therapist	15,736	17,572	535,251	30.46	7
8	Rehab/Therapy Aides	18,695	21,906	328,909	15.01	8
9	Activity Director	3,606	4,105	95,400	23.24	9
10	Activity Assistants	15,659	17,946	358,233	19.96	10
11	Social Service Workers	18,923	21,433	432,911	20.20	11
12	Dietician	5,925	6,784	140,073	20.65	12
13	Food Service Supervisor	3,854	4,289	142,487	33.22	13
14	Head Cook	1,919	2,144	37,024	17.27	14
15	Cook Helpers/Assistants	56,017	62,300	742,038	11.91	15
16	Dishwashers	45,482	48,829	443,012	9.07	16
17	Maintenance Workers					17
18	Housekeepers	104,144	115,281	1,383,975	12.01	18
19	Laundry	22,160	25,137	305,453	12.15	19
20	Administrator	1,648	1,819	123,935	68.13	20
21	Assistant Administrator	1,643	1,819	74,027	40.70	21
22	Other Administrative	27,790	32,144	754,265	23.47	22
23	Office Manager					23
24	Clerical	7,265	7,957	111,382	14.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,821	2,090	81,743	39.11	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,765	4,372	83,193	19.03	31
32	Other Health C: Nsg Sect/WC	17,977	20,746	336,182	16.20	32
33	Other(specify) Barber/Beauty	2,451	2,865	55,113	19.24	33
34	TOTAL (lines 1 - 33)	845,259	950,704	\$ 17,243,148 *	\$ 18.14	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		\$		35
36	Medical Director				36
37	Medical Records Consultant	65	1,960	Ln 10, C 3	37
38	Nurse Consultant	90	4,520	Ln 10, C 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	7,854	466,317	Ln 10a,C 8	40
41	Occupational Therapy Consultant	4,718	280,141	Ln 10a,C 8	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3,004	178,406	Ln 10a,C 8	43
44	Activity Consultant				44
45	Social Service Consultant	58	3,312	Ln 12,C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	15,789	\$ 934,656		49

C. CONTRACT NURSES

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

Facility Name & ID Number Du Page Convalescent Center

0008201

Report Period Beginning: Dec. 1, 2006

Ending: Nov. 30, 2007

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Beth Welch	Administrator	None	\$ 123,935	Workers' Compensation Insurance	\$ 18,344	IDPH License Fee	\$	
Jennifer Ulmer	Asst. Administrator	None	74,026	Unemployment Compensation Insurance	41,836	Advertising: Employee Recruitment		
				FICA Taxes	1,259,606	Health Care Worker Background Check		
				Employee Health Insurance	2,086,986	(Indicate # of checks performed <u>310</u>)	6,200	
				Employee Meals		Life Svcs Network	21,492	
				Illinois Municipal Retirement Fund (IMRF)*	1,533,712	Joint Commission	1,040	
				Workers Comp Claims	262,733	Polaris Group	1,500	
				Other Contractual Benefit Expense	2,897	DuPage County Health Dept	2,250	
						Illinois Dept of Public Health	1,990	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 197,961			Various Other Amounts-per sch	4,084	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Other Contractual Costs (From County) for Security, Personnel, Purchasing & County Board [Detail on Schedule VIII]			\$ 587,416			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 587,416	TOTAL (agree to Schedule V, line 22, col.8)	\$ 5,206,114	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 38,556	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
County Finance & A/P	Finance & AP		\$ 40,275	N/A		\$	Out-of-State Travel	\$
County Auditor	Financial Audit		5,546					
County Acctg & Budget	Accounting		30,829					
Other Misc	Cost Reprt & Acctg Svcs		21,330				In-State Travel	1,687
							Seminar Expense	8,353
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 97,980	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 10,040

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Srvcs Network \$21492
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 106,609 Line 10, Col 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. \$ 278,130
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. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 899,244
- (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? NONE
- 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? N/A
- 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: Wolf & Company, CPA's The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Final Audit Rpt not yet available
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.