

Facility Name & ID Number Du Page Convalescent Center

0008201 Report Period Beginning: Dec. 1, 2008 Ending: Nov. 30, 2009

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	508	Skilled (SNF)	508	185,420	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	508	TOTALS	508	185,420	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	93,223	15,545	9,403	118,171	8
9	SNF/PED					9
10	ICF	974			974	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	94,197	15,545	9,403	119,145	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.26%

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 & Pharmacy

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

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 8,183

Medicare Intermediary Wisconsin Physicians Service (WPS)

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: YE 11/30/2009 Fiscal Year: YE 11/30/2009

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

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	1,576,143	114,379	3,592	1,694,114		1,694,114	(591,583)	1,102,531		1
2	Food Purchase		1,093,644		1,093,644		1,093,644	(381,900)	711,744		2
3	Housekeeping	1,370,565	122,771	61,571	1,554,907		1,554,907	(144,996)	1,409,911		3
4	Laundry	292,323	86,924	12,756	392,003		392,003	(1,756)	390,247		4
5	Heat and Other Utilities			1,597,474	1,597,474		1,597,474		1,597,474		5
6	Maintenance			867,507	867,507		867,507	27,092	894,599		6
7	Other (specify):*										7
8	TOTAL General Services	3,239,031	1,417,718	2,542,900	7,199,649		7,199,649	(1,093,143)	6,106,506		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	11,873,371	641,554	1,035,308	13,550,233		13,550,233		13,550,233		10
10a	Therapy	628,777	37,734	526	667,037		667,037		667,037		10a
11	Activities	412,802	14,079	299	427,180		427,180		427,180		11
12	Social Services	452,101	936	1,766	454,803		454,803		454,803		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	13,367,051	694,303	1,037,899	15,099,253		15,099,253		15,099,253		16
	C. General Administration										
17	Administrative	217,804		591,302	809,106		809,106	96,427	905,533		17
18	Directors Fees										18
19	Professional Services			121,767	121,767		121,767		121,767		19
20	Dues, Fees, Subscriptions & Promotions			164,993	164,993		164,993	(114,804)	50,189		20
21	Clerical & General Office Expenses	909,151	145,153	75,947	1,130,251		1,130,251	(9,823)	1,120,428		21
22	Employee Benefits & Payroll Taxes			5,712,899	5,712,899		5,712,899	6,609	5,719,508		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,159	15,159		15,159		15,159		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			247,231	247,231		247,231		247,231		26
27	Other (specify):*										27
28	TOTAL General Administration	1,126,955	145,153	6,929,298	8,201,406		8,201,406	(21,591)	8,179,815		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	17,733,037	2,257,174	10,510,097	30,500,308		30,500,308	(1,114,734)	29,385,574		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, 2008 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			1,155,141	1,155,141		1,155,141	10,358	1,165,499			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			96,486	96,486		96,486		96,486			35
36	Other (specify):*											36
37	TOTAL Ownership			1,251,627	1,251,627		1,251,627	10,358	1,261,985			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	411,077	2,547,929	34,160	2,993,166		2,993,166		2,993,166			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							278,130	278,130			42
43	Other (specify):* Cnty NH MA Tax							7,955,227	7,955,227			43
44	TOTAL Special Cost Centers	411,077	2,547,929	34,160	2,993,166		2,993,166	8,233,357	11,226,523			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	18,144,114	4,805,103	11,795,884	34,745,101		34,745,101	7,128,981	41,874,082			45

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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Cafeteria Income - Other Dietary Costs	\$ (129,446)	1	1
2	Cafeteria Income - Food	(83,565)	2	2
3	421 Cafeteria Income - Other Dietary Costs	(462,137)	1	3
4	421 Cafeteria Income - Food	(298,335)	2	4
5	Other Misc Revenues	(6,122)	21	5
6	Overpayments and Refunds expense	(114,804)	20	6
7	West Campus Cleaning Revenue	(144,996)	3	7
8	Commissions for Telephone and Vending	(106,910)	6	8
9	Indirect FICA cost adjustment	6,609	22	9
10	Indirect Furnishings expense adjustment	166	6	10
11	Indirect Repairs expense adjustment	133,836	6	11
12	County Board Expense	21,256	17	12
13	County Treasurer and County Clerk Expense	75,171	17	13
14	Provider Participation Fee	278,130	42	14
15	HFS County Nrsng Home Contribution Tax Exp.	7,955,227	43	15
16	Loss on Sale Of Capital Assets - Equipment	10,358	30	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	7,134,438		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center

0008201

Report Period Beginning:

Dec. 1, 2008

Ending:

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(591,583)	0	0	0	0	0	0	0	0	0	0	(591,583)	1
2	Food Purchase	(381,900)	0	0	0	0	0	0	0	0	0	0	(381,900)	2
3	Housekeeping	(144,996)	0	0	0	0	0	0	0	0	0	0	(144,996)	3
4	Laundry	(1,756)	0	0	0	0	0	0	0	0	0	0	(1,756)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	27,092	0	0	0	0	0	0	0	0	0	0	27,092	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,093,143)	0	(1,093,143)	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	96,427	0	0	0	0	0	0	0	0	0	0	96,427	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(114,804)	0	0	0	0	0	0	0	0	0	0	(114,804)	20
21	Clerical & General Office Expenses	(9,823)	0	0	0	0	0	0	0	0	0	0	(9,823)	21
22	Employee Benefits & Payroll Taxes	6,609	0	0	0	0	0	0	0	0	0	0	6,609	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	(21,591)	0	(21,591)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,114,734)	0	(1,114,734)	29									

STATE OF ILLINOIS

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Report Period Beginning:

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Summary B

Nov. 30, 2009

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	10,358	0	0	0	0	0	0	0	0	0	0	10,358	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	10,358	0	10,358	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):*	7,955,227	0	0	0	0	0	0	0	0	0	0	7,955,227	43
44	TOTAL Special Cost Centers	8,233,357	0	8,233,357	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,128,981	0	7,128,981	45									

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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
Du Page County	100.00	N/A		N/A		
(Du Page Convalescent Center is a subunit of Du Page County. See Sch. VIII for Allocations of costs from the County.)						

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	N/A	\$			\$	\$	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

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Report Period Beginning: Dec. 1, 2008

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

0008201 Report Period Beginning: Dec. 1, 2008 Ending: Nov. 30, 2009

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	I.M.R.F. & Social Security	Direct Cost	25,092,703	3015	\$ 25,092,703	\$ 0	2,792,851	\$ 2,792,851	1
2	6	Furniture & Furnishings	Direct Cost	19,486	46	19,486	0	166	166	2
3	19	Finance & AP	# of A/P Claims	41,580	184	572,244	326,353	3,947	54,321	3
4	19	County Audit	% of Time Spent	262,574	11	262,574	0	10,502	10,502	4
5	19	County Auditor	# of A/P Claims	40,716	183	52,727	31,548	3,947	5,111	5
6	19	General Acctg & Budget	% of All Depts	1,583,070	53	1,583,070	902,753	29,869	29,869	6
7	21	Mail Delivery	Wtd Avg # of Del	303,805	45	303,805	196,829	6,966	6,966	7
8	22	Workers Comp Expense	Dir Cost & FTEs/Clms	1,818,836	3015	1,818,836	0	263,303	263,303	8
9	26	Property Insurance	Building Value %	341,705	45	341,705	0	29,073	29,073	9
10	26	Gen/Prof Liability Insurance	Direct Cost/FTE/Hd Ct	763,134	3015	763,134	0	198,227	198,227	10
11	26	Surety Bond & Premiums	Direct Cost/FTE's	39,957	2424	39,957	0	7,147	7,147	11
12	22	Unemployment Comp Ins	Direct Cost/FTE	122,171	2493	122,171	0	14,156	14,156	12
13	26	Service retention Fee	# of Ins Claims	152	19	97,157	0	20	12,784	13
14	5	Space Allocation	Square Footage	2,447,933	46	2,447,933	1,116,794	508,769	508,769	14
15	5	Power Plant cost	Square Footage	3,860,953	42	3,860,953	1,761,441	241,078	241,078	15
16	17	Security	Square Footage	1,173,441	45	1,173,441	718,856	192,410	192,410	16
17	6	Building Maintenance	Direct Cost	2,676,221	46	2,676,221	1,220,944	859,879	859,879	17
18	6	Repair & Maint cost	Square Footage	969,734	43	969,734	462,840	133,836	133,836	18
19	35	Rental of Equipment	Direct Cost	16,217	43	16,217	0	1,380	1,380	19
20	6	Repair & Maint of DP Equip	Direct Cost	45,618	43	45,618	0	7,628	7,628	20
21	17	Personnel Costs & Benfts Adm	FTEs	1,674,110	63	1,674,110	937,206	322,864	322,864	21
22	17	Purchasing Costs	# of Purchase Orders	930,330	100	930,330	530,617	76,027	76,027	22
23	17	County Board	Comm Assignments	950,673	49	950,673	950,673	21,256	21,256	23
24		(Continued on Page 8A)								24
25	TOTALS					\$ 45,814,799	\$ 9,156,854		\$ 5,789,603	25

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	17	County Treasurer	# of Checks	49	\$ 67,842	\$ 67,842	67,842	\$ 67,842	1
2	17	County Clerk	# of Related Orders	49	7,329	7,329	7,329	7,329	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				\$ 75,171	\$ 75,171		\$ 75,171	25

Facility Name & ID Number

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

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

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 257,371 B. General Construction Type: Exterior Masonry Reinf Cnert 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 Organization) offices and buildings are next to and across the street (County Farm Road) 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>Nursing Home Bldgs</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, 2008 Ending: Nov. 30, 2009

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	288		1947	1947	\$ 70,858	\$	30	\$	\$	\$ 70,858	4
5	104			1978	4,456,548		30			4,456,548	5
6	16			1979	1,750,524	48624	30	48,624		1,750,524	6
7				1983	1,172,064	34473	34	34,473		916,394	7
8				1993	6,516,821	233927	Various	233,927		4,037,092	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	9,994	20	9,994		199,053	17
18		Oxygen Manifold - North Bldg		1990	5,423	271	20	271		5,130	18
19		Ground North & Hydrotherapy remodel		1991	331,513	10,828	15/20/25	10,828		308,157	19
20		Window replacement, 3-Center & Nurse station remodel		1992	604,207	21,450	10/15/20/25	21,450		553,049	20
21		Laundry water heater & softners, asphalt rep & landscape		1993	588,826	22,106	10/12/15/20	22,106		500,428	21
22		ADA & Elevator upgrades, Nurse station remodel & misc		1994	105,577	3,487	5/10/15/20	3,487		90,823	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	13,101	5/10/20	13,101		219,923	25
26		Elevator Pit ladders & automatic entrance doors		1998	10,922	143	10/20	143		9,760	26
27		Lobby remodel, Carpet, Elevator safety system & HVAC		1999	701,043	56,998	5/10/20	56,998		669,646	27
28		Tubs, Reception, Laundry, Kitchen Elev, HVAC & access eqp		2000	848,131	69,538	5/10/15/20	69,538		728,618	28
29		Tub room remodel, Life safety system, Elev & Liq Oxygen eqp		2001	473,208	47,321	10	47,321		379,726	29
30		Carpeting, incl North Day Room		2002	8,582		5			8,582	30
31		Roof rehab, Card readers & Kitchen renovation		2002	219,254	21,926	10	21,926		157,238	31
32		Fire Alarm Dampers, Fire System & Constructn Admin		2002	1,515,449	151,545	10	151,545		1,060,850	32
33		Director Signage		2002	65,448	3,272	20	3,272		23,179	33
34		HVAC Modifications		2002	102,341	6,823	15	6,823		47,759	34
35		Curtain Wall Installation		2003	13,140	876	15	876		5,621	35
36		Carpet Installation		2003	1,148		5			1,148	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, 2008 Ending: Nov. 30, 2009

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	\$ 872	25	\$ 872	\$	\$ 5,961	37
38	Curtain Wall Project	2003	338,936	33,893	10	33,893		206,186	38
39	Alarm System Prof Fees	2003	1,000		5			1,000	39
40	Fire Alarm System Replacement	2004	165,176	16,517	10	16,517		92,223	40
41	Hi-Res LW Light Camera	2004	2,768	462	5	462		2,768	41
42	Rekey Main Entrance & Door Contact Installation	2004	1,733	115	5	115		1,733	42
43	Pharmacy Storage Remodeling	2004	2,050	205	10	205		1,161	43
44	Reconfigure Front	2005	6,599	659	10	659		3,244	44
45	Commercial Carpet	2005	4,357	435	10	435		2,142	45
46	Air Handler CC	2005	75,447	7,545	10	7,545		34,580	46
47	New Door	2005	3,295	659	5	659		2,966	47
48	Wireless Exterior Gate	2005	12,010	2,402	5	2,402		10,409	48
49	Roof Top HVAC in Residents Dining Rm	2005	7,235	723	10	723		3,014	49
50	Floor Preparation	2005	721	73	10	73		343	50
51	North Entrance Badge Reader	2005	1,712	343	5	343		1,598	51
52	Wanderer System	2005	2,970	594	5	594		2,624	52
53	Relocate Card Reader - Door 4, Ground Floor	2005	2,704	541	5	541		2,299	53
54	Asst Administrators Office Carpet	2005	1,068	214	5	214		908	54
55	Fiber /PBX FON System	2005	2,842	569	5	569		2,274	55
56	Alarm Installation	2005	2,475	247	10	247		990	56
57	Door Repairs - 2 items	2005	8,463	1,692	5	1,692		6,770	57
58	Patch & Repair	2005	2,902	581	5	581		2,322	58
59	Fire Pump and Installation	2005	58,432	5,844	10	5,844		23,373	59
60	Steel Frame and Door	2006	2,136	427	5	427		1,495	60
61	Sidewalk Installation	2006	4,111	411	10	411		1,405	61
62	Laundry Room Lighting	2006	2,790	558	5	558		1,814	62
63	Locksmith - Lock Rekeyings (2)	2006	3,109	622	5	622		1,969	63
64	Laundry Room Lighting	2006	2,557	512	5	512		1,577	64
65	Parking Lot Painting	2006	291	58	5	58		179	65
66	HVAC Modifications	2006	1,802,424	90,122	20	90,122		270,364	66
67	Laundry Room Renovation	2006	701,152	70,115	10	70,115		210,345	67
68	Fire Pump Installation	2006	135,000	13,500	10	13,500		40,500	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 28,005,706	\$ 1,008,213		\$ 1,008,213	\$	\$ 21,684,576	70

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

Facility Name & ID Number Du Page Convalescent Center

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Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 28,005,706	\$ 1,008,213		\$ 1,008,213	\$	\$ 21,684,576	1
2	Building Permit for Office Relocation	2009	5,230	196	20	196		196	2
3	Kitchen Roof Top Airhandler	2009	10,908		10				3
4	One East Dining Room Flooring	2009	9,664		10				4
5	Flooring Replacement for 3 - Center	2009	18,900		5				5
6	Unlocated - Depr Reconcile adj to TB / Rounding diff			5		5			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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 28,050,408	\$ 1,008,414		\$ 1,008,414	\$	\$ 21,684,772	34

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

Facility Name & ID Number Du Page Convalescent Center

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Report Period Beginning:

Dec. 1, 2008

Ending:

Nov. 30, 2009

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	\$ 1,855,533	\$ 142,101	\$ 152,459	\$ 10,358	5-15	\$ 1,609,302	71
72	Current Year Purchases	425,461	1,170	1,170		5-10	1,170	72
73	Fully Depreciated Assets	2,715,111					2,715,111	73
74	CY Deletions	(229,966)				10-15	(229,966)	74
75	TOTALS	\$ 4,766,139	\$ 143,271	\$ 153,629	\$ 10,358		\$ 4,095,617	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	317	317		10	12,685	77
78	Maint & Transport	Ford A-10 Van	2000	38,971				4	38,971	78
79	Maint & Transport	Window Van - 2001	2001	31,396	3,139	3,139		10	25,116	79
80	TOTALS			\$ 265,583	\$ 3,456	\$ 3,456	\$		\$ 259,303	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)	\$ 33,876,490	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,155,141	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,165,499	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,358	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 26,039,692	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	NONE	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Misc CIP	\$ 608,914	92
93			93
94			94
95		\$ 608,914	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								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

N/A

This amount was calculated by dividing the total amount to be amortized 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: \$ 96,486 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	<u>None</u>		\$	\$	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2008 Ending: Nov. 30, 2009

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><u>The Cert. Nurses Aides hired already had training.</u></p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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					
					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	2532 hrs	166,231				2,532	166,231	4
5	Physician Care	Ln 10, Col 8	visits		7,210	36,000		7,210	36,000	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 8	# of prescripts	411,077			2,547,929	73,544	2,959,006	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 577,308	7,210	\$ 36,000	\$ 2,547,929	83,286	\$ 3,161,237	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, 2008

Ending:

Nov. 30, 2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Nov. 30, 2009 (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	\$ 2,925,053	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>500,000</u>)	2,755,678		3
4	Supply Inventory (priced at <u>Cost</u>)	427,673		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)	\$ 6,108,404	\$	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	28,050,407		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,714,407		16
17	Accumulated Depreciation (book methods)	(26,039,692)		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>)	608,914		22
23	Other(specify): <u>Capital Leased Equipmnt</u>	317,314		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,435,710	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,544,114	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,047,847	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,664,092		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>	298,125		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,010,064	\$	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 Compensation</u>	1,361,007		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,361,007	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,371,071	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 14,060,913	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,431,984	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,582,784	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,582,784	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	478,129	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)	\$ 478,129	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)	\$ 14,060,913	24 *

* This must agree with page 17, line 47.

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	\$ 28,471,136	1
2	Discounts and Allowances for all Levels	(3,894,984)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 24,576,152	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,539,222	6
7	Oxygen	13,453	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,552,675	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,400,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	973,483	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,396,342	17
18	Sale of Supplies to Non-Patients	6,122	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,755	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,777,702	23
	D. Non-Operating Revenue		
24	Contributions	28,999	24
25	Interest and Other Investment Income***	46,154	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 75,153	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>West Campus Cleaning Revenue</u>	144,996	28
28a	<u>Misc. Other - Vending / Loss on Sale of FA</u>	96,552	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 241,548	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 35,223,230	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	7,199,649	31
32	Health Care	15,099,253	32
33	General Administration	8,201,406	33
	B. Capital Expense		
34	Ownership	1,251,627	34
	C. Ancillary Expense		
35	Special Cost Centers	2,993,166	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)*	\$ 34,745,101	40
41	Income before Income Taxes (line 30 minus line 40)**	478,129	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 478,129	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, 2008

Ending:

Nov. 30, 2009

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	1,819	2,086	\$ 119,885	\$ 57.47	1
2	Assistant Director of Nursing	3,348	4,171	175,537	42.09	2
3	Registered Nurses	107,908	123,210	4,005,934	32.51	3
4	Licensed Practical Nurses	39,826	44,577	1,204,232	27.01	4
5	CNAs & Orderlies	338,314	385,539	5,914,964	15.34	5
6	CNA Trainees					6
7	Licensed Therapist	16,083	20,091	577,309	28.73	7
8	Rehab/Therapy Aides	20,477	24,056	379,534	15.78	8
9	Activity Director	3,574	4,280	105,075	24.55	9
10	Activity Assistants	16,580	19,214	307,727	16.02	10
11	Social Service Workers	18,613	21,588	452,101	20.94	11
12	Dietician	6,250	7,159	151,443	21.15	12
13	Food Service Supervisor	5,659	6,486	224,042	34.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	53,897	60,437	744,713	12.32	15
16	Dishwashers	47,498	49,961	455,945	9.13	16
17	Maintenance Workers					17
18	Housekeepers	104,930	117,812	1,370,565	11.63	18
19	Laundry	22,306	25,806	292,323	11.33	19
20	Administrator	1,594	1,842	131,376	71.32	20
21	Assistant Administrator	1,657	1,850	83,428	45.10	21
22	Other Administrative	29,288	34,524	807,705	23.40	22
23	Office Manager					23
24	Clerical	5,763	6,647	101,446	15.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,818	2,014	83,011	41.22	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,543	4,183	82,617	19.75	31
32	Other Health C: <u>Nsg Sect/WC</u>	19,037	21,948	370,202	16.87	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	869,782	989,481	\$ 18,141,114 *	\$ 18.33	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			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant	8,117	418,375	Ln 10a,C 8	40
41	Occupational Therapy Consultant	5,136	264,726	Ln 10a,C 8	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4,258	219,494	Ln 10a,C 8	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,540	Ln 12,C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	17,535	\$ 904,135		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, 2008

Ending: Nov. 30, 2009

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	\$ 131,376	Workers' Compensation Insurance	\$ 17,760	IDPH License Fee	\$		
Jennifer Ulmer	Asst. Administrator	None	86,428	Unemployment Compensation Insurance	14,156	Advertising: Employee Recruitment			
				FICA Taxes	1,329,643	Health Care Worker Background Check			
				Employee Health Insurance	2,644,592	(Indicate # of checks performed <u>290</u>)	5,800		
				Employee Meals		Life Srvcs Network	29,687		
				Illinois Municipal Retirement Fund (IMRF)*	1,463,208	Joint Commission	3,945		
				Workers Comp Claims	245,543	Polaris Group	1,800		
				Other Contractual Benefit Expense	4,606	DuPage County Health Dept	2,250		
						Illinois Dept of Public Health	1,990		
						Various Other Amounts-per Sch	4,717		
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()		
(List each licensed administrator separately.)			\$ 217,804			Non-allowable advertising	()		
						Yellow page advertising	()		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 50,189		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Other Contractual Costs (From County) for Security, Personnel, Purchasing & County Board [Detail on Schedule VIII]			\$ 591,302	N/A		\$	Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 591,302				In-State Travel	1,485	
(Attach a copy of any management service agreement)							Seminar Expense	13,674	
C. Professional Services									
Vendor/Payee	Type		Amount						
County Finance & A/P	Finance & AP		\$ 64,823						
County Auditor	Financial Auditing		5,111						
County Acctg & Budget	Accounting		29,869						
Other Misc	Cost Reprt & Acctg Srvcs		21,964						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 121,767					(agree to Sch. V, line 24, col. 8)	\$ 15,159

* 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 Services Network \$29,687
- (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. \$ 160,389 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. \$ 973,483
- (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
- (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.