





Facility Name & ID Number DuPage Convalescent Center

# 0008201 Report Period Beginning: Dec. 1, 2012 Ending: Nov. 30, 2013

**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	368	Skilled (SNF)	368	134,320	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	368	TOTALS	368	134,320	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	82,381	24,650	9,020	116,051	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	82,381	24,650	9,020	116,051	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.40%

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)

Employee Meals, Empl. Pharmacy, Therapy, County Laundry

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 01/01/1935

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 368 and days of care provided 7,719

Medicare Intermediary Wisconsin Physicians Service (WPS)

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: YE 11/30/2013 Fiscal Year: YE 11/30/2013

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



Facility Name &amp; ID Number

DuPage Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2012

Ending:

Nov. 30, 2013

**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
	<b>A. General Services</b>										
1	Dietary	1,631,259	105,785	736	1,737,780		1,737,780	(421,454)	1,316,326		1
2	Food Purchase		1,183,138		1,183,138		1,183,138	(286,941)	896,197		2
3	Housekeeping	1,225,116	156,985	42,433	1,424,534		1,424,534	(1,575)	1,422,959		3
4	Laundry	295,464	115,813	39	411,316		411,316	(1,253)	410,063		4
5	Heat and Other Utilities			1,571,230	1,571,230		1,571,230		1,571,230		5
6	Maintenance		20,099	971,693	991,792		991,792	31,032	1,022,824		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	3,151,839	1,581,820	2,586,131	7,319,790		7,319,790	(680,191)	6,639,599		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	12,219,711	649,812	1,199,479	14,069,002	(1,049,950)	13,019,052		13,019,052		10
10a	Therapy	590,986	43,742		634,728		634,728		634,728		10a
11	Activities	432,514	6,042	78	438,634		438,634		438,634		11
12	Social Services	451,582	1,144	3,513	456,239		456,239		456,239		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	13,694,793	700,740	1,203,070	15,598,603	(1,049,950)	14,548,653		14,548,653		16
	<b>C. General Administration</b>										
17	Administrative	271,539	1	734,521	1,006,061		1,006,061	94,982	1,101,043		17
18	Directors Fees										18
19	Professional Services			158,711	158,711		158,711	10,645	169,356		19
20	Dues, Fees, Subscriptions & Promotions			196,720	196,720		196,720	(157,803)	38,917		20
21	Clerical & General Office Expenses	900,352	129,511	81,812	1,111,675		1,111,675	(50,188)	1,061,487		21
22	Employee Benefits & Payroll Taxes			7,070,468	7,070,468		7,070,468	765	7,071,233		22
23	Inservice Training & Education										23
24	Travel and Seminar			83,517	83,517		83,517		83,517		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			239,961	239,961		239,961		239,961		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	1,171,891	129,512	8,565,710	9,867,113		9,867,113	(101,599)	9,765,514		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	18,018,523	2,412,072	12,354,911	32,785,506	(1,049,950)	31,735,556	(781,790)	30,953,766		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.

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#0008201

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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	
	<b>D. Ownership</b>											
30	Depreciation			1,076,611	1,076,611		1,076,611		1,076,611			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			195,005	195,005		195,005		195,005			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,271,616	1,271,616		1,271,616		1,271,616			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	444,783	2,041,814	85,104	2,571,701	1,049,950	3,621,651		3,621,651			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							201,480	201,480			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	444,783	2,041,814	85,104	2,571,701	1,049,950	3,621,651	201,480	3,823,131			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	18,463,306	4,453,886	13,711,631	36,628,823		36,628,823	(580,310)	36,048,513			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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,253)	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	(6,544)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (7,797)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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 <b>Pg 5A Total</b>	(566,434)	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (566,434)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (574,231)		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						44
45	Other-Attach Schedule <u>Therapy</u>	X		1,049,950	10	45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 1,049,950		47

DuPage Convalescent Center

ID# 0008201

Report Period Beginning: Dec. 1, 2012

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Cafeteria Income - Other Dietary Costs	\$ (153,367)	1	1
2	Cafeteria Income - Food Costs	(104,418)	2	2
3	421 Cafeteria Income - Other Dietary Costs	(268,087)	1	3
4	421 Cafeteria Income - Food	(182,523)	2	4
5	Other Misc Revenues	(43,644)	21	5
6	Overpayments and Refunds expense	(157,803)	20	6
7	West Campus Cleaning Revenue	(1,575)	3	7
8	Commissions for Vending	(90,798)	6	8
9	Provider Participation Fee	201,480	42	9
10	Indirect FICA cost adjustment	765	22	10
11	County Audit Expense	10,645	19	11
12	Indirect Repairs expense adjustment	121,830	6	12
13	County Board Expense	19,811	17	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	<b>Total</b>		(572,513)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number DuPage Convalescent Center# 0008201

Report Period Beginning:

Dec. 1, 2012

Ending:

Nov. 30, 2013

## 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)	
	<b>A. General Services</b>													
1	Dietary	(421,454)	0	0	0	0	0	0	0	0	0	0	(421,454)	1
2	Food Purchase	(286,941)	0	0	0	0	0	0	0	0	0	0	(286,941)	2
3	Housekeeping	(1,575)	0	0	0	0	0	0	0	0	0	0	(1,575)	3
4	Laundry	(1,253)	0	0	0	0	0	0	0	0	0	0	(1,253)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	31,032	0	0	0	0	0	0	0	0	0	0	31,032	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(680,191)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(680,191)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	94,982	0	0	0	0	0	0	0	0	0	0	94,982	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	10,645	0	0	0	0	0	0	0	0	0	0	10,645	19
20	Fees, Subscriptions & Promotions	(157,803)	0	0	0	0	0	0	0	0	0	0	(157,803)	20
21	Clerical & General Office Expenses	(50,188)	0	0	0	0	0	0	0	0	0	0	(50,188)	21
22	Employee Benefits & Payroll Taxes	765	0	0	0	0	0	0	0	0	0	0	765	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	<b>TOTAL General Administration</b>	<b>(101,599)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(101,599)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(781,790)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(781,790)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DuPage Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2012 Ending:

Nov. 30, 2013

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

	Capital Expense	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)
	<b>D. Ownership</b>												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	201,480	0	0	0	0	0	0	0	0	0	0	201,480 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>201,480</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>201,480 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(580,310)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(580,310) 45</b>

Facility Name & ID Number DuPage Convalescent Center

# 0008201

Report Period Beginning: Dec. 1, 2012 Ending: Nov. 30, 2013

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DuPage County	100.00	None		None		
(DuPage Convalescent Center is a subunit of DuPage 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	\$	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.

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 DuPage Convalescent Center

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VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization DuPage 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

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.

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	20,324,552	171	\$ 20,324,552	\$ 0	3,466,275	\$ 3,466,275	1
2	19	Finance & AP	# of A/P Claims	9,639,135	171	9,639,135	320,052	71,869	71,869	2
3	19	County Audit	% of Time Spent	266,118	11	266,118	0	10,645	10,645	3
4	19	County Auditor Allocation	# of A/P Claims	38,241	170	118,742	70,464	4,445	13,802	4
5	19	General Acctg & Budget	% of All Depts	1,558,016	52	1,558,016	795,477	29,962	29,962	5
6	21	Mail Delivery	Wtd Avg # of Del	372,119	45	372,119	189,993	8,633	8,633	6
7	22	Workers Comp Claims	Direct Cost	1,928,859	0	1,928,859	0	269,119	269,119	7
8	22	Workers Comp Premiums	# of FTEs / # of Clms	251,707	2800	251,707	0	35,452	35,452	8
9	26	Property Insurance	Building Value %	337,753	54	337,753	0	29,023	29,023	9
10	26	Auto Liability Claims	Direct Cost	66,092	0	66,092	0	16	16	10
11	26	General Liability Claims	Direct Cost	20,419	0	20,419	0	3,584	3,584	11
12	26	General Liability Premiums	FTE's/Direct Cost/#Vh	516,318	2800	516,318	0	177,673	177,673	12
13	26	Surety Bonds & Premiums	Direct Cost / FTEs	47,777	2800	47,777	0	8,942	8,942	13
14	22	Unemployment Comp Claims	Direct Cost	254,211	0	254,211	0	57,191	57,191	14
15	22	Unemplymnt Comp Premiums	FTEs	5,436	2800	5,436	0	726	726	15
16	26	Service retention Fee	Dir Cost/#of Ins Clms	94,773	15	94,773	0	20,723	20,723	16
17	19	Ins Broker/Consultnt Fees	FTEs	133,400	2800	133,400	0	17,818	17,818	17
18	5	Space Allocation	Square Footage	2,660,957	54	2,660,957	1,214,293	570,490	570,490	18
19	5	Power Plant	Square Footage	4,588,021	50	4,588,021	2,093,666	353,508	353,508	19
20	17	Security	Square Footage	1,435,506	52	1,435,506	321,729	356,625	356,625	20
21	6	Building Maintenance	Direct Cost	2,662,005	0	2,662,005	1,214,761	820,802	820,802	21
22	6	Rep/Mtc Rd/Signal/Drain Systm	Square Footage	877,823	50	877,823	373,690	121,830	121,830	22
23	35	Rental of Mach & Equipment	Direct Cost	9,333	0	9,333	0	1,233	1,233	23
24		(Continued on Page 8A)								24
25	TOTALS					\$ 48,169,072	\$ 6,594,125		\$ 6,445,941	25

Facility Name & ID Number DuPage Convalescent Center

# 0008201 Report Period Beginning: Dec. 1, 2012 Ending: v. 30, 2013

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

Name of Related Organization DuPage 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Repair & Maint of DP Equip	Direct Cost	28,993	\$ 28,993	\$ 2,375	2,375	\$ 2,375	1	
2	17	Service Awards	Direct Cost	181,437	181,437	2,732	2,732	2,732	2	
3	17	Personnel Costs & Benfts Adm	FTEs	1,384,540	61	1,384,540	720,210	297,482	297,482	3
4	17	Purchasing Costs	# of Purchase Orders	967,528	85	967,528	493,992	71,300	71,300	4
5	17	County Board	Comm Assignmnts \$	926,089	45	926,089	926,089	19,811	19,811	5
6	17	County Treasurer	# of Checks	67,842	48	67,842	67,842	67,842	67,842	6
7	17	County Clerk	# of Related Orders	7,329	48	7,329	7,329	7,329	7,329	7
8									8	
9									9	
10									10	
11									11	
12									12	
13									13	
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21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 3,563,758	\$ 2,140,291		\$ 468,871	25	



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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>		
1. Real Estate Tax accrual used on 2012 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2008	_____	8	
	2009	_____	9	
	2010	_____	10	
	2011	_____	11	
	2012	_____	12	
<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2012	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DuPage Convalescent Center COUNTY Du Page  
 FACILITY IDPH LICENSE NUMBER 0008201  
 CONTACT PERSON REGARDING THIS REPORT Patrick Szajkovics  
 TELEPHONE (630) 530-7100, Ext. 111 FAX #: (630) 530-7106

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(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.	<u>N/A - No Real Estate Tax paid on</u>	<u>County Home</u>	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 257,371 B. General Construction Type: Exterior Masonry Rnf Concret 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).

The Du Page County Government (Parent Organization) offices and buildings are next to and across 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>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>400,000</b>		<b>\$ 794,360</b>	<b>3</b>

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	148		1947	1979	\$ 70,858	\$	30	\$	\$	\$ 70,858
5	104			1978	4,456,548		30			4,456,548
6	16			1979	1,750,524		30			1,750,524
7				1983	1,172,064	34,472	34	34,472		1,054,284
8	100			1993	6,516,821	233,928	10/12/15/20	233,928		4,972,804
	<b>Improvement Type**</b>									
9		Mech room renovation & heat exchangers		1976	44,372		20			44,372
10		Alarm equip doors & other, Project 181		1977	8,545		20			8,545
11		Cyclone dust collector		1978	12,188		20			12,188
12		Flagpole		1979	844		20			844
13		Kitchen floor / Ground north remodel		1981	212,304		20			212,304
14		South Bldg renovation - Phase III ( Per 1989 Adj)		1983	3,871,516		20			3,871,516
15		South Bldg renovation - Phase III Architect fees		1983	262,953		20			262,953
16		Laundry, 3-Center & Nurse station remodel		1985	91,792		15/20			91,792
17		Tubs & Parking lot projects		1989	199,883		20			199,883
18		Oxygen Manifold - North Bldg		1990	5,423		20			5,423
19		Ground North & Hydrotherapy remodel		1991	331,513	649	15/20/25	649		331,513
20		Window replacement, 3-Center & Nurse station remodel		1992	604,207	436	10/15/20/25	436		604,207
21		Laundry water heater & softners, asphalt rep & landscape		1993	588,825	22,106	10/12/15/20	22,106		588,825
22		ADA & Elevator upgrades, Nurse station remodel & misc		1994	105,577	3,250	5/10/15/20	3,250		103,822
23		Sewer Ejector pumps & Carpet replacement		1995	35,064		5/10			35,064
24		Carpet replace in Recreation & Volunteer areas & misc		1996	4,356		5			4,356
25		Chilled water bridges, Liquid oxygen, Lights refit & Elevtr		1997	320,587	13,104	5/10/20	13,104		272,338
26		Elevator Pit ladders & automatic entrance doors		1998	10,922	142	10/20	142		10,329
27		Lobby remodel, Carpet, Elevator safety system & HVAC		1999	701,043	3,209	5/10/20	3,209		682,483
28		Tubs, Receptn, Lndry, Kitchen Elev, HVAC & access eqp		2000	832,461	10,627	5/10/15/20	10,627		809,393
29		Tub rm remodel, Life safety syst, Elev & Liq Oxygen eqp		2001	473,208		10			473,208
30		Fire Alarm System, Roof, HVAC and various other		2002	1,911,073	10,097	5/10/15/20	10,097		1,854,604
31		Curtain Wall, Fencing and other assets		2003	376,034	32,817	5/10/15/25	32,817		359,660
32		Fire Alarm System Replacement and other assets		2004	182,683	17,818	5/10	17,818		174,546
33		Air Handler CC, Fire Pump Install and various other assets		2005	182,276	14,431	5/10	14,431		157,990
34		HVAC Modifications, Laundry Rm Renovatn & various other		2006	2,653,570	174,147	5/10/20	174,147		1,230,087
35										
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

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Facility Name &amp; ID Number DuPage Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2012 Ending: Nov. 30, 2013

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37	Building Permit for Office Relocation	2009	\$ 5,230	\$ 261	20	\$ 261	\$	\$ 1,242
38	Kitchen Roof Top Airhandler	2009	10,908	1,091	10	1,091		4,363
39	One East Dining Room Flooring	2009	9,664	966	10	966		3,865
40	Flooring Replacement for 3 - Center	2009	18,900	3,780	5	3,780		15,120
41	Carpet / Floor Tile Removal	2009	2,605	261	10	261		1,020
42	Fire Protection - Life Safety	2009	79,152	7,915	10	7,915		31,001
43	New Lobby Entrance	2009	18,992	1,899	10	1,899		7,439
44	Window Replacement	2009	115,487	11,549	10	11,549		45,232
45	Nurse Call System	2009	180,441	18,044	10	18,044		70,672
46	Roof Replacement	2009	13,500	900	15	900		3,525
47	Resident Dining Room Roof Replacement	2009	107,567	7,171	15	7,171		28,087
48	West Corridor Extension Project	2009	79,193	7,919	10	7,919		31,017
49								
50	Transfer of Nurse Call System	2010	3,996	400	10	400		1,465
51	Lighting Study	2010	4,900	980	5	980		3,430
52	South Building Renovation	2010	1,100,966	55,048	20	55,048		188,082
53	Elevator Card Reader Install	2010	1,844	369	5	369		1,230
54	Bldg Permit, East Hallway Renovation	2010	875	175	5	175		569
55	Eastwing Ground Floor Renovation	2010	92,414	4,621	20	4,621		14,247
56	Building Needs Assessment	2010	20,121	4,024	5	4,024		12,072
57	Henry Hyde Marquee Sign	2010	29,225	2,922	10	2,922		8,767
58	1 North Day Room Remodeling	2010	8,382	838	10	838		2,515
59								
60	Upgrade of Fire System	2011	11,539	1,154	10	1,154		3,077
61	Medical Vacuum	2011	27,983	2,798	10	2,798		7,462
62	WI FI Installation	2011	4,007	801	5	801		2,070
63	Lavatory Sink in Volunteers Bathroom	2011	747	75	10	75		187
64	Smoke Detectors and Equipment Installation	2011	15,916	1,592	10	1,592		3,979
65	Hot Water Heater	2011	13,639	2,728	5	2,728		6,592
66	Door Frame for Tub Room	2011	612	61	10	61		148
67	Carpeting	2011	4,134	827	5	827		1,929
68	Renovation of 4 Shower Floors	2011	62,904	6,290	10	6,290		14,678
69	Plumbing for Volunteer Office Bathroom	2011	6,215	621	10	621		1,398
70	TOTAL (lines 4 thru 69)		\$ 30,042,092	\$ 719,313		\$ 719,313	\$	\$ 25,223,743

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

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Facility Name &amp; ID Number DuPage Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2012 Ending: Nov. 30, 2013

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 30,042,092	\$ 719,313		\$ 719,313	\$	\$ 25,223,743
2	Fire Safety Material and Installation	2011	3,409	341	10	341		682
3	Roof Exhaust Supplies - East Wing	2011	5,004	500	10	500		1,001
4	Supply & Install Fire Rated Ceiling Tile	2011	3,512	351	10	351		702
5	Door Closures Fire Safe Replacements	2011	11,435	1,143	10	1,143		2,287
6	Driveway Replacement	2011	20,512	4,102	5	4,102		8,205
7	Replacement of Flooring	2011	12,808	2,562	5	2,562		5,123
8	Replacement Flooring	2011	10,700	2,140	5	2,140		4,280
9	Big Beam LED Exit Signs	2011	15,069	1,507	10	1,507		3,014
10	Wellness Center	2011	161,412	16,141	10	16,141		32,282
11	Shower Room Floors	2011	13,137	1,314	10	1,314		2,627
12								
13	Window Replacement	2012	5,915	1,183	5	1,183		2,169
14	Flooring Install - North Day Rms	2012	10,919	2,184	5	2,184		3,458
15	Cabling for Resident TVs	2012	65,956	13,191	5	13,191		17,588
16	Furnish/Install Pipes, Hot Water System	2012	30,063	6,013	5	6,013		7,516
17	Material/ Install Laundry Barco Joints	2012	8,027	803	10	803		870
18	Dayroom Survey Documents	2012	19,945	1,995	10	1,995		2,161
19	Wellness Center Flooring	2012	14,698	2,940	5	2,940		2,940
20	Roof Repair and Roof Walk Installation	2012	51,079	5,108	10	5,108		5,108
21	Flooring Projects	2012	28,994	5,799	5	5,799		5,799
22	Resident Dining Rm Flooring	2012	52,255	10,451	5	10,451		10,451
23	Cable Install for Wireless Access	2012	75,762	15,152	5	15,152		15,152
24	Barco Joints - Laundry Rm	2012	6,568	657	10	657		657
25	Window Replacement Project	2012	20,549	2,055	10	2,055		2,055
26								
27	Furnish / Install Handrails in Stairwell #1	2013	10,000	1,667	5	1,667		1,667
28	Furnish / Install Handrails	2013	16,600	1,245	10	1,245		1,245
29	Smokers Outside Shelter	2013	3,835	511	5	511		511
30	Nurse Call System	2013	79,067		5			
31	Replacement Flooring Project: For PT Sr. Staff Offices, 2-East							
32	Day Rms. (North & South), 1 & 2 East Empl Break Rooms	2013	26,686		10			
33								
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 30,826,008	\$ 820,368		\$ 820,368	\$	\$ 25,363,293

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

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Facility Name & ID Number DuPage Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2012 Ending: Nov. 30, 2013

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 30,826,008	\$ 820,368		\$ 820,368	\$	\$ 25,363,293
2							
3							
4							
5	2013	68,211		10			
6	2013	4,400		10			
7	2013	68,616		10			
8							
9		(1)	(914)		(914)		(888)
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34		\$ 30,967,234	\$ 819,454		\$ 819,454	\$	\$ 25,362,405

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

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Facility Name & ID Number DuPage Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2012

Ending:

Nov. 30, 2013

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Costs-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 5,232,766	\$ 228,438	\$ 228,438	\$		\$ 4,820,310	71
72	Current Year Purchases	24,644	600	600		5	600	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 5,257,410	\$ 229,038	\$ 229,038	\$		\$ 4,820,910	75

**D. Vehicle Costs. (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Snowplow & Maint/02 Van	Var-97 Ford Van/Window Van	Var to '85-02	\$ 265,583	\$	\$	\$	3/4/10	\$ 265,583	76
77	Maint & Transport	Ford 2010 F250 Extended Van	2010	32,280	6,456	6,456		5	20,982	77
78	Maint & Transport	Ford 2010 F-550 Passngr van	2010	77,015	15,403	15,403		5	48,776	78
79	Maint & Transport	Extended Length Van	2011	31,300	6,260	6,260		5	12,520	79
80	<b>TOTALS</b>			\$ 406,178	\$ 28,119	\$ 28,119	\$		\$ 347,861	80

**E. Summary of Care-Related Assets**

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 37,425,182	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,076,611	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,076,611	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 30,531,176	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92	Misc CIP	\$ 564,720	92
93			93
94			94
95		\$ 564,720	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 DuPage Convalescent Center

# 0008201

Report Period Beginning: Dec. 1, 2012

Ending: Nov. 30, 2013

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

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

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

N/A

9. Option to Buy:  YES  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: \$ 195,005 Description: Facility Medical and Office Equipment (See Pg 14A Attached)

(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>N/A</u>	<u>N/A</u>	\$ <u>N/A</u>	\$ <u>N/A</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. \_\_\_\_\_/2014 \$ \_\_\_\_\_

13. \_\_\_\_\_/2015 \$ \_\_\_\_\_

14. \_\_\_\_\_/2016 \$ \_\_\_\_\_

\* 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.

**DuPage Convalescent Center**  
**Year Ended 11/30/2013 State # 0008201**  
**Equipment Rental Expense Summary**

		FY' 12		FY' 13		Reallocatio				
		Per A601T23P	Accrual	Accrual	Refund	n of	Expense	Per G/L	Per F140T	Difference
4500-3510	Administration	\$ 42,450.31	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 42,450.31	\$ 40,440.92	\$ (2,009.39)
4501-3510	Nursing Admin	\$ 106,967.03	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 106,967.03	\$ 106,967.03	\$ 0.00
4504-3510	Business Office	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4507-3510	Pharmacy	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4509-3510	Clinical Support	\$ 10,809.67	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 10,809.67	\$ 10,809.67	\$ (0.00)
4510-3510	Volunteer	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4514-3510	Dietary	\$ 4,179.45	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,179.45	\$ 4,179.45	\$ -
4516-3510	Housekeeping	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,009.39	\$ 2,009.39
4523-3510	1 East	\$ 29,299.76	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 29,299.76	\$ 29,299.76	\$ (0.00)
4538-3510	Offsite Cafeteria	\$ 66.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 66.00	\$ 66.00	\$ -
4599-3510	Indirect Cost All	\$ -	\$ -	\$ 1,232.73	\$ -	\$ -	\$ -	\$ 1,232.73	\$ 1,232.73	\$ -
		\$ 193,772.22	\$ -	\$ 1,232.73	\$ -	\$ -	\$ -	\$ 195,004.95	\$ 195,004.95	\$ 0.00

(A) Note: This expense has been reclassified out, per F140T work papers, from the various departments indicated here and to Line 35 of Schedule VI. Also see schedule in work papers for details on vendor and type of equipment rented.

Facility Name & ID Number

DuPage Convalescent Center

#

0008201

Report Period Beginning:

Dec. 1, 2012 Ending:

Nov. 30, 2013

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?</p> <p><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 that were 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		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)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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	1845 hrs	75,891				1,845	75,891	4
5	Physician Care	Ln 10, Col 8	visits		240	36,000		240	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	140,511			2,002,031	61,563	2,142,542	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	<b>TOTAL</b>			\$ 216,402	240	\$ 36,000	\$ 2,002,031	63,648	\$ 2,254,433	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Nov. 30, 2013 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 2,121,440	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>500,000</u> )	5,990,979		3
4	Supply Inventory (priced at )	346,120		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):	28,086		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 8,486,625	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	784,360		13
14	Buildings, at Historical Cost	30,967,234		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,346,273		16
17	Accumulated Depreciation (book methods)	(30,531,176)		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 (spec CIP)	564,720		22
23	Other(specify): <u>Capital Lease</u>	317,315		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 7,448,726	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 15,935,351	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 3,705,657	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,206,169		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
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued PTO and Other Liab</u>	2,998,376		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 7,910,202	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Accrued Compensation - LT</u>	1,296,478		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,296,478	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 9,206,680	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 6,728,671	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 15,935,351	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,635,058	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,635,058	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(4,302,058)	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) <b>Rounding Difference</b>		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (4,302,058)	17
<b>B. Transfers (Itemize):</b>			
18	<b>Capital Contributions at YE</b>	3,395,671	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 3,395,671	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,728,671	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	
<b>I. Revenue</b>		<b>Amount</b>	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 37,855,659	1
2	Discounts and Allowances for all Levels	(15,608,169)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 22,247,490	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients	16,140	5
6	Therapy	3,592,339	6
7	Oxygen	86,332	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,694,811	8
<b>C. Other Operating Revenue</b>			
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	708,395	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,090,300	17
18	Sale of Supplies to Non-Patients	43,644	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,253	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,243,592	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	33,580	24
25	Interest and Other Investment Income****	3,661	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 37,241	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	West Cmps Cling Rev \$1575 /Loss on Disp (6079)	(4,505)	28
28a	Other - Vending \$90798 / AR Write Offs \$61	90,860	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 86,355	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 32,309,489	30

		2	
<b>II. Expenses</b>		<b>Amount</b>	
<b>A. Operating Expenses</b>			
31	General Services	6,639,599	31
32	Health Care	14,548,653	32
33	General Administration	9,765,514	33
<b>B. Capital Expense</b>			
34	Ownership	1,271,616	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,621,651	35
36	Provider Participation Fee	201,480	36
<b>D. Other Expenses (specify):</b>			
37	Add Back Offsets	580,310	37
38	Other Unidentified reconciling amount	(17,276)	38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 36,611,547	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(4,302,058)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (4,302,058)	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 12,130,144	44
45	Private Pay - Net Inpatient Revenue	6,228,511	45
46	Medicare - Net Inpatient Revenue	3,888,835	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 22,247,490	49

\* 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 DuPage Convalescent Center

# 0008201

Report Period Beginning:

Dec. 1, 2012

Ending:

Nov. 30, 2013

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	1,825	2,091	\$ 126,225	\$ 60.37	1
2	Assistant Director of Nursing	3,166	5,621	226,792	40.35	2
3	Registered Nurses	128,236	148,683	4,775,918	32.12	3
4	Licensed Practical Nurses	34,666	39,345	961,724	24.44	4
5	CNAs & Orderlies	331,707	378,760	5,645,987	14.91	5
6	CNA Trainees					6
7	Licensed Therapist	1,845	2,231	75,891	34.02	7
8	Rehab/Therapy Aides	25,772	32,415	509,632	15.72	8
9	Activity Director	5,302	6,458	160,670	24.88	9
10	Activity Assistants	16,045	18,556	271,844	14.65	10
11	Social Service Workers	17,664	20,866	451,582	21.64	11
12	Dietician	5,506	6,457	135,163	20.93	12
13	Food Service Supervisor	9,331	10,776	342,112	31.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,437	20,267	319,519	15.77	15
16	Dishwashers	77,540	84,857	834,465	9.83	16
17	Maintenance Workers					17
18	Housekeepers	90,440	104,537	1,225,179	11.72	18
19	Laundry	24,208	28,156	295,437	10.49	19
20	Administrator	1,759	2,303	143,924	62.49	20
21	Assistant Administrator	2,878	3,363	127,615	37.95	21
22	Other Administrative	14,256	16,207	305,928	18.88	22
23	Office Manager					23
24	Clerical	22,711	27,114	594,424	21.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	76	126	5,463	43.36	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,702	4,271	82,578	19.33	31
32	Other Health C: <u>Nsg Sect/WC</u>	19,096	22,661	400,451	17.67	32
33	Other(specify) <u>Ancill Svcs</u>	13,942	17,066	444,783	26.06	33
34	TOTAL (lines 1 - 33)	869,110	1,003,187	\$ 18,463,306 *	\$ 18.40	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		\$	
36	Medical Director			
37	Medical Records Consultant			
38	Nurse Consultant			
39	Pharmacist Consultant			
40	Physical Therapy Consultant	9,670	530,050	L10&39,C3
41	Occupational Therapy Consultant	6,227	341,337	L10&39,C3
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant	3,258	178,563	L10&39,C3
44	Activity Consultant			
45	Social Service Consultant	24	1,632	Ln 12, C3
46	Other(specify)			
47				
48				
49	TOTAL (lines 35 - 48)	19,179	\$ 1,051,582	

C. CONTRACT NURSES

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

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Du Page Convalescent Center  
Year Ended 11/30/2013  
Legal Fees Detail

Sch. XIX  
Page 21

<u>Vendor</u>	<u>Reason</u>	<u>Amount</u>	<u>Dept</u>	<u>Total</u>
Kopon Airdo, LLC	Legal Consulting Services Regarding IDPH Survey	\$ 6,381.50	4500	\$ 6,381.50
		<u>\$ 6,381.50</u>		<u>\$ 6,381.50</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					5 FY2007	6 FY2008	7 FY2009	8 FY2010	9 FY2011	10 FY2012	11 FY2013	12 FY2014	13 FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
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20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 Svcs Network \$19664
- (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. \$ 162,453 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. \$ 201,480  
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. \$ 708,395
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees