		FOR BHF USE			

LL1

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0008201

Facility Name: Du Page Convalescent Center

Address: 400 N County Farm Rd (Number) Wheaton (City) 60187 (Zip Code)

County: Du Page

Telephone Number: (630) 665-6400 **Fax #** (630) 784-4212

HFS ID Number:

Date of Initial License for Current Owners: 1/1/1935

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	X	
[ ]	Trust	[ ]	Partnership	[ ]	State
		[ ]	Corporation	X	County
		[ ]	"Sub-S" Corp.	[ ]	Other
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from Dec. 1, 2009 to Nov. 30, 2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	03/25/2011 (Date)
	(Type or Print Name)	Beth Welch
	(Title)	Administrator
Paid Preparer	(Signed)	03/25/2011 (Date)
	(Print Name and Title)	Patrick Szajkovics, Senior Consultant
	(Firm Name & Address)	Strategic Reimbursement, Inc., 360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126
	(Telephone)	(630) 530-7100 Fax # (630) 530-7106

In the event there are further questions about this report, please contact:
Name: Patrick Szajkovics, Sr. Consultant Telephone Number: (630) 530-7100, Ext. 111
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	93,560	11,869	8,459	113,888	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	93,560	11,869	8,459	113,888	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.42%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1935

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date ______ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 368 and days of care provided 7,394

Medicare Intermediary Wisconsin Physicians Service (WPS)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: YE 11/30/2010 Fiscal Year: YE 11/30/2010

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

Facility Name & ID Number: Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,572,726	92,188	1,952	1,666,866		1,666,866	(488,399)	1,178,467			1
2	Food Purchase		1,067,236		1,067,236		1,067,236	(312,705)	754,531			2
3	Housekeeping	1,351,010	139,609	70,291	1,560,910		1,560,910	(139,462)	1,421,448			3
4	Laundry	305,375	107,296	10,194	422,865		422,865	(1,858)	421,007			4
5	Heat and Other Utilities			1,554,497	1,554,497		1,554,497	0	1,554,497			5
6	Maintenance			1,036,022	1,036,022		1,036,022	(93,771)	942,251			6
7	Other (specify):*				0		0	0	0			7
8	**TOTAL General Services**	3,229,111	1,406,329	2,672,956	7,308,396	0	7,308,396	(1,036,195)	6,272,201			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	11,765,030	604,667	950,668	13,320,365	(832,579)	12,487,786	0	12,487,786			10
10a	Therapy	546,226	34,887	500	581,613	832,579	1,414,192	0	1,414,192			10a
11	Activities	419,281	13,299	33	432,613		432,613	0	432,613			11
12	Social Services	444,725	1,058	1,534	447,317		447,317	0	447,317			12
13	CNA Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	13,175,262	653,911	952,735	14,781,908	0	14,781,908	0	14,781,908			16
	C. General Administration											
17	Administrative	225,583		1,285,468	1,511,051	(594,212)	916,839	96,593	1,013,432			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			134,961	134,961		134,961	0	134,961			19
20	Dues, Fees, Subscriptions & Promotions			98,913	98,913		98,913	(88,024)	10,889			20
21	Clerical & General Office Expenses	1,019,006	42,201	78,987	1,140,194		1,140,194	(32,838)	1,107,356			21
22	Employee Benefits & Payroll Taxes			5,897,923	5,897,923		5,897,923	973	5,898,896			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar			15,438	15,438		15,438	0	15,438			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			266,079	266,079		266,079	0	266,079			26
27	Other (specify):*				0		0	0	0			27
28	**TOTAL General Administration**	1,244,589	42,201	7,777,769	9,064,559	(594,212)	8,470,347	(23,296)	8,447,051			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	17,648,962	2,102,441	11,403,460	31,154,863	(594,212)	30,560,651	(1,059,491)	29,501,160			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, 2009 Ending: Nov. 30, 2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,167,933	1,167,933		1,167,933	244	1,168,177			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			121,665	121,665		121,665	0	121,665			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			1,289,598	1,289,598	0	1,289,598	244	1,289,842			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers	456,525	2,495,245	67,318	3,019,088		3,019,088	0	3,019,088			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee				0		0	278,130	278,130			42
43	Other (specify):* HFS Cnty NH Tx				0	594,212	594,212	0	594,212			43
44	TOTAL Special Cost Centers	456,525	2,495,245	67,318	3,019,088	594,212	3,613,300	278,130	3,891,430			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	18,105,487	4,597,686	12,760,376	35,463,549	0	35,463,549	(781,117)	34,682,432			45

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(1,858)	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	(5,475)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (7,333)		$ 0	30

BHF USE ONLY

48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule **Pg 5A Total**	(774,272)	Pg 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (774,272)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (781,605)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	HFS Cnty Nrsg Home Contr Tax	X		594,212	17	44
45	Other-Attach Schedule **Therapy**	X		832,579	10	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,426,791		47

STATE OF ILLINOIS

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: Dec. 1, 2009

Ending: Nov. 30, 2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cafeteria Income - Other Dietary Costs	$ (125,142)	1	1
2	Cafeteria Income - Food	(80,124)	2	2
3	421 Cafeteria Income - Other Dietary Costs	(363,257)	1	3
4	421 Cafeteria Income - Food	(232,581)	2	4
5	Other Misc Revenues	(27,363)	21	5
6	Overpayments and Refunds expense	(88,024)	20	6
7	West Campus Cleaning Revenue	(139,462)	3	7
8	Commissions for Telephone and Vending	(210,308)	6	8
9	Indirect IMRF cost adjustment	(260,015)	22	9
10	Indirect FICA cost adjustment	260,988	22	10
11	Indirect Repairs expense adjustment	116,537	6	11
12	County Board Expense	21,422	17	12
13	County Treasurer Expense	67,842	17	13
14	County Clerk Expense	7,329	17	14
15	Provider Participation Fee	278,130	42	15
16	Loss on Sale Of Capital Assets - Equipment	244	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**	(773,784)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(488,399)	0	0	0	0	0	0	0	0	0	0	(488,399)	1
2	Food Purchase	(312,705)	0	0	0	0	0	0	0	0	0	0	(312,705)	2
3	Housekeeping	(139,462)	0	0	0	0	0	0	0	0	0	0	(139,462)	3
4	Laundry	(1,858)	0	0	0	0	0	0	0	0	0	0	(1,858)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(93,771)	0	0	0	0	0	0	0	0	0	0	(93,771)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,036,195)	0	0	0	0	0	0	0	0	0	0	(1,036,195)	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	96,593	0	0	0	0	0	0	0	0	0	0	96,593	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	(88,024)	0	0	0	0	0	0	0	0	0	0	(88,024)	20
21	Clerical & General Office Expenses	(32,838)	0	0	0	0	0	0	0	0	0	0	(32,838)	21
22	Employee Benefits & Payroll Taxes	973	0	0	0	0	0	0	0	0	0	0	973	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**	(23,296)	0	0	0	0	0	0	0	0	0	0	(23,296)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,059,491)	0	0	0	0	0	0	0	0	0	0	(1,059,491)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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)	
	D. Ownership													
30	Depreciation	244	0	0	0	0	0	0	0	0	0	0	244	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	244	0	0	0	0	0	0	0	0	0	0	244	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	278,130	0	0	0	0	0	0	0	0	0	0	278,130	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	278,130	0	0	0	0	0	0	0	0	0	0	278,130	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(781,117)	0	0	0	0	0	0	0	0	0	0	(781,117)	45

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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, 2009 Ending: ›v. 30, 2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	I.M.R.F. & Social Security	Direct Cost	26,981,656	3007	$ 26,981,656	$ 0	2,944,001	$ 2,944,001	1
2	19	Finance & AP	# of A/P Claims	44,296	181	597,901	329,032	4,449	60,052	2
3	19	County Audit	% of Time Spent	263,270	11	263,270	0	10,531	10,531	3
4	19	County Auditor	# of A/P Claims	43,360	180	57,362	34,395	4,449	5,886	4
5	19	General Acctg & Budget	% of All Depts	1,618,637	53	1,618,637	890,754	30,540	30,540	5
6	21	Mail Delivery	Wtd Avg # of Del	373,495	45	373,495	205,538	8,533	8,533	6
7	22	Workers Comp Expense	Dir Cost & FTEs/Clms	2,854,641	3007	2,854,641	0	212,110	212,110	7
8	26	Property Insurance	Building Value %	345,011	45	345,011	0	29,464	29,464	8
9	26	Gen/Prof Liability Insurance	Direct Cost/FTE/Hd Ct	900,823	45	900,823	0	195,534	195,534	9
10	26	Surety Bond & Premiums	Direct Cost/FTE's	77,969	2464	77,969	0	11,211	11,211	10
11	22	Unemployment Comp Ins	Direct Cost/FTE's	161,407	3007	161,407	0	25,537	25,537	11
12	26	Service retention Fee	# of Ins Claims	194	19	137,973	0	42	29,870	12
13	5	Space Allocation	Square Footage	2,285,494	56	2,285,494	1,045,625	537,187	537,187	13
14	5	Power Plant	Square Footage	4,277,384	56	4,277,384	1,956,925	273,041	273,041	14
15	17	Security	Square Footage	1,204,356	52	1,204,356	701,900	206,139	206,139	15
16	6	Building Maintenance	Direct Cost	2,905,106	52	2,905,106	1,329,101	1,029,496	1,029,496	16
17	6	Repair & Mtc Rd, Signal, Drain	Square Footage	841,115	50	841,115	400,168	116,537	116,537	17
18	35	Rental of Equipment	Direct Cost	13,578	45	13,578	0	1,470	1,470	18
19	6	Repair & Maint of DP Equip	Direct Cost	44,184	45	44,184	0	6,426	6,426	19
20	20	Statutory & Fiscal Charges	Direct Cost	22,160	56	22,160	0	40	40	20
21	17	Personnel Costs & Benfts Adm	FTEs	2,014,827	68	2,014,827	1,004,764	397,352	397,352	21
22	17	Purchasing Costs	# of Purchase Orders	996,535	105	996,535	548,405	87,764	87,764	22
23	17	County Board	Comm Assignments	955,469	49	955,469	955,469	21,422	21,422	23
24		(Continued on Page 8A)								24
25	TOTALS					$ 49,930,353	$ 9,402,076		$ 6,240,143	25

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: ›v. 30, 2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	County Treasurer	# of Checks	67,842	49	$ 67,842	$ 67,842	67,842	$ 67,842	1
2	17	County Clerk	# of Related Orders	7,329	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 Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 0	15

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

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

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item	Amount	Line
1. Real Estate Tax accrual used on 2009 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).	$ 0	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		Line
2005		8
2006		9
2007		10
2008		11
2009		12

	FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2009 $	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Du Page Convalescent Center COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0008201

CONTACT PERSON REGARDING THIS REPORT Patrick 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Concrete Frame Steel Number of Stories 5

C. Does the Operating Entity? [X] (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? [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home Bldgs	400,000	1947	$ 794,360	1
2					2
3	TOTALS	400,000		$ 794,360	3

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	288		1947	1947	$ 70,858	$	30	$	$	$ 70,858	4
5	104			1978	4,456,548	0	30	0		4,456,548	5
6	16			1979	1,750,524	0	30	0		1,750,524	6
7				1983	1,172,064	34473	34	34,473		950,867	7
8	100			1993	6,516,821	233927	10/12/15/20	233,927		4,271,020	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	0	15/20			91,792	16
17	Tubs & Parking lot projects			1989	199,883	830	20	830		199,883	17
18	Oxygen Manifold - North Bldg			1990	5,423	271	20	271		5,401	18
19	Ground North & Hydrotherapy remodel			1991	331,513	10,828	15/20/25	10,828		318,985	19
20	Window replacement, 3-Center & Nurse station remodel			1992	604,207	21,450	10/15/20/25	21,450		574,589	20
21	Laundry water heater & softners, asphalt rep & landscape			1993	588,826	22,106	10/12/15/20	22,106		522,534	21
22	ADA & Elevator upgrades, Nurse station remodel & misc			1994	105,577	3,250	5/10/15/20	3,250		94,073	22
23	Sewer Ejector pumps & Carpet replacement			1995	31,457	0	5/10	0		31,457	23
24	Carpet replace in Recreation & Volunteer areas & misc			1996	7,963	0	5			7,963	24
25	Chilled water bridges, Liquid oxygen, Lights refit & Elevator			1997	320,587	13,104	5/10/20	13,104		233,027	25
26	Elevator Pit ladders & automatic entrance doors			1998	10,922	142	10/20	142		9,902	26
27	Lobby remodel, Carpet, Elevator safety system & HVAC			1999	701,043	3,209	5/10/20	3,209		672,855	27
28	Tubs, Reception, Laundry, Kitchen Elev, HVAC & access eqp			2000	848,131	64,564	5/10/15/20	64,564		793,182	28
29	Tub room remodel, Life safety system, Elev & Liq Oxygen eqp			2001	473,208	47,321	10	47,321		427,047	29
30	Carpeting, incl North Day Room			2002	8,582	0	5	0		8,582	30
31	Roof rehab, Card readers & Kitchen renovation			2002	219,254	21,926	10	21,926		179,163	31
32	Fire Alarm Dampers, Fire System & Constructn Admin			2002	1,515,449	151,545	10	151,545		1,212,395	32
33	Director Signage			2002	65,448	3,273	20	3,273		26,452	33
34	HVAC Modifications			2002	102,341	6,823	15	6,823		54,582	34
35	Curtain Wall Installation			2003	13,140	876	15	876		6,497	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

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	
37	Fencing - Wrought Iron	2003	$ 21,810	$ 873	25	$ 873	$	$ 6,834	37
38	Curtain Wall Project	2003	338,936	33,894	10	33,894		240,080	38
39	Alarm System Prof Fees	2003	1,000	0	5	0		1,000	39
40	Fire Alarm System Replacement	2004	165,176	16,518	10	16,518		108,741	40
41	Hi-Res LW Light Camera	2004	2,768	0	5	0		2,768	41
42	Rekey Main Entrance & Door Contact Installation	2004	1,733	0	5	0		1,733	42
43	Pharmacy Storage Remodeling	2004	2,050	205	10	205		1,366	43
44	Reconfigure Front	2005	6,599	660	10	660		3,904	44
45	Commercial Carpet	2005	4,357	436	10	436		2,578	45
46	Air Handler CC	2005	75,447	7,545	10	7,545		42,125	46
47	New Door	2005	3,295	329	5	329		3,295	47
48	Wireless Exterior Gate	2005	12,010	1,601	5	1,601		12,010	48
49	Roof Top HVAC in Residents Dining Rm	2005	7,235	724	10	724		3,738	49
50	Floor Preparation	2005	721	72	10	72		415	50
51	North Entrance Badge Reader	2005	1,712	114	5	114		1,712	51
52	Wanderer System	2005	2,970	346	5	346		2,970	52
53	Relocate Card Reader - Door 4, Ground Floor	2005	2,704	405	5	405		2,704	53
54	Asst Administrators Office Carpet	2005	1,068	160	5	160		1,068	54
55	Fiber /PBX FON System	2005	2,842	568	5	568		2,842	55
56	Alarm Installation	2005	2,475	248	10	248		1,238	56
57	Door Repairs - 2 items	2005	8,463	1,693	5	1,693		8,463	57
58	Patch & Repair	2005	2,902	580	5	580		2,902	58
59	Fire Pump and Installation	2005	58,432	5,843	10	5,843		29,216	59
60	Steel Frame and Door	2006	2,136	427	5	427		1,922	60
61	Sidewalk Installation	2006	4,111	411	10	411		1,816	61
62	Laundry Room Lighting	2006	2,790	558	5	558		2,372	62
63	Locksmith - Lock Rekeyings (2)	2006	3,109	622	5	622		2,591	63
64	Laundry Room Lighting	2006	2,557	511	5	511		2,088	64
65	Parking Lot Painting	2006	291	59	5	59		238	65
66	HVAC Modifications	2006	1,802,424	90,121	20	90,121		360,485	66
67	Laundry Room Renovation	2006	701,152	70,116	10	70,116		280,461	67
68	Fire Pump Installation	2006	135,000	13,500	10	13,500		54,000	68
69									69
70	TOTAL (lines 4 thru 69)		$ 28,005,706	$ 889,057		$ 889,057	$ 0	$ 22,573,723	70

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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	$ 889,057		$ 889,057	$	$ 22,573,723	1
2	Building Permit for Office Relocation	2009	5,230	262	20	262		458	2
3	Kitchen Roof Top Airhandler	2009	10,908	1,091	10	1,091		1,091	3
4	One East Dining Room Flooring	2009	9,664	966	10	966		966	4
5	Flooring Replacement for 3 - Center	2009	18,900	3,780	5	3,780		3,780	5
6	Transfer of Nurse Call System	2010	3,996	266	10	266		266	6
7	Carpet / Floor Tile Removal	2010	2,605	239	10	239		239	7
8	Fire Protection - Life Safety	2010	79,152	7,256	10	7,256		7,256	8
9	New Lobby Entrance	2010	18,992	1,741	10	1,741		1,741	9
10	Window Replacement	2010	115,487	10,586	10	10,586		10,586	10
11	Nurse Call System	2010	180,441	16,540	10	16,540		16,540	11
12	Roof Replacement	2010	13,500	825	15	825		825	12
13	Resident Dining Room Roof Replacement	2010	107,567	6,573	15	6,573		6,573	13
14	West Corridor Extension Project	2010	79,193	7,259	10	7,259		7,259	14
15	Lighting Study	2010	4,900	490	5	490		490	15
16	Elevator Card Reader Install	2010	1,844	123	5	123		123	16
17	Bldg Permit, East Hallway Renovation	2010	875	44	5	44		44	17
18	Eastwing Ground Floor Renovation	2010	92,414	385	20	385		385	18
19	South Building Renovation	2010	1,100,966	22,937	20	22,937		22,937	19
20	Building Needs Assessment	2010	20,121	0	5	0		0	20
21	Henry Hyde Marquee Sign	2010	29,225	0	10	0		0	21
22	1 North Day Room Remodeling	2010	8,382	0	10	0		0	22
23									23
24									24
25	Unlocated - Depr Reconcile adj to TB / Rounding diff		(1)	(2)		(2)		(92)	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 29,910,067	$ 970,418		$ 970,418	$ 0	$ 22,655,190	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,879,208	$ 176,142	$ 176,386	$ 244	5-15	$ 1,398,627	71
72	Current Year Purchases	233,025	14,052	14,052	0	5-10	14,052	72
73	Fully Depreciated Assets	2,873,375			0		2,873,375	73
74	CY Deletions	(74,559)			0	10-15	(74,559)	74
75	TOTALS	$ 4,911,049	$ 190,194	$ 190,438	$ 244		$ 4,211,495	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	$ 234,187	$ 0	$ 0	$ 0	3/4/10	$ 234,187	76
77	Maint & Transport	Ford 2010 F250 Extended Van	2010	32,280	1,614	1,614	0	5	1,614	77
78	Maint & Transport	Ford 2010 F-550 Passngr van	2010	77,015	2,567	2,567	0	5	2,567	78
79	Maint & Transport	Window Van - 2001	2001	31,396	3,140	3,140	0	10	28,256	79
80	TOTALS			$ 374,878	$ 7,321	$ 7,321	$ 0		$ 266,624	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)	$ 35,990,354	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,167,933	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,168,177	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 235	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 27,133,309	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	$ 302,813	92
93			93
94			94
95		$ 302,813	95

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

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

Facility Name & ID Number: Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 121,665 Description: Facility Medical and Office Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

The Cert. Nurses Aides hired already had training.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist			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	1653	hrs	66,273				1,653	66,273	4
5	Physician Care	Ln 10, Col 8		visits		9,090	36,000		9,090	36,000	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	Ln 39, Col 8	69803	# of prescrpts				2,494,996	69,803	2,494,996	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				$ 66,273	9,090	$ 36,000	$ 2,494,996	80,546	$ 2,597,269	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 # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of Nov. 30, 2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,075,147	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 500,000)	1,909,187		3
4	Supply Inventory (priced at Cost)	402,181		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)**	$ 3,386,515	$ 0	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	29,910,067		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,968,612		16
17	Accumulated Depreciation (book methods)	(27,133,311)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	302,813		22
23	Other(specify):	317,315		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,149,856	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,536,371	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,135,439	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,699,197		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	Other Misc Accrued Liab	280,270		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,114,906	$ 0	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	Accrued Compensation	1,464,493		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,464,493	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,579,399	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,956,972	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,536,371	$ 0	48

*(See instructions.)

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,173,043	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,173,043	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(7,910,289)	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)**	$ (7,910,289)	17
	B. Transfers (Itemize):		
18	Capital Contributions	4,694,218	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 4,694,218	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,956,972	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 21,184,874	1
2	Discounts and Allowances for all Levels	(3,200,716)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 17,984,158	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,832,880	6
7	Oxygen	18,903	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 2,851,783	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,550,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	801,104	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,922,093	17
18	Sale of Supplies to Non-Patients	27,363	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,858	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 6,302,418	23
	D. Non-Operating Revenue		
24	Contributions	57,303	24
25	Interest and Other Investment Income***	8,073	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 65,376	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	West Campus Cleaning Revenue	139,462	28
28a	Misc. Other - Vending / Loss on Sale of FA	210,063	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 349,525	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 27,553,260	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	7,308,396	31
32	Health Care	14,781,908	32
33	General Administration	9,064,559	33
	B. Capital Expense		
34	Ownership	1,289,598	34
	C. Ancillary Expense		
35	Special Cost Centers	3,019,088	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)*	$ 35,463,549	40
41	Income before Income Taxes (line 30 minus line 40)**	(7,910,289)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (7,910,289)	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, 2009 Ending: Nov. 30, 2010

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	1,758	2,089	$ 120,412	$ 57.64	1
2	Assistant Director of Nursing	3,387	4,177	177,723	42.55	2
3	Registered Nurses	111,926	127,652	4,084,074	31.99	3
4	Licensed Practical Nurses	40,341	45,232	1,198,363	26.49	4
5	CNAs & Orderlies	332,073	381,160	5,740,282	15.06	5
6	CNA Trainees					6
7	Licensed Therapist	16,286	18,719	522,797	27.93	7
8	Rehab/Therapy Aides	21,651	25,095	395,660	15.77	8
9	Activity Director	3,546	4,277	105,890	24.76	9
10	Activity Assistants	16,895	19,625	313,391	15.97	10
11	Social Service Workers	18,354	21,302	444,725	20.88	11
12	Dietician	6,185	7,021	150,660	21.46	12
13	Food Service Supervisor	5,561	6,408	223,854	34.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	53,497	59,758	742,155	12.42	15
16	Dishwashers	46,317	49,875	456,057	9.14	16
17	Maintenance Workers					17
18	Housekeepers	102,377	116,032	1,351,010	11.64	18
19	Laundry	24,583	27,991	305,375	10.91	19
20	Administrator	1,637	1,941	140,482	72.38	20
21	Assistant Administrator	1,589	1,761	85,101	48.33	21
22	Other Administrative	31,466	39,262	910,738	23.20	22
23	Office Manager					23
24	Clerical	6,371	7,279	108,268	14.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,803	2,027	84,293	41.59	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,590	4,153	83,540	20.12	31
32	Other Health C: Nsg Sect/WC	17,830	21,272	360,637	16.95	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	869,023	994,108	$ 18,105,487 *	$ 18.21	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	7,789	421,535	Ln 10, C3	40
41	Occupational Therapy Consultant	3,089	167,099	Ln 10, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4,507	243,945	Ln 10, C3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,528	Ln 12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	15,409	$ 834,107		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, 2009 Ending: Nov. 30, 2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Beth Welch	Administrator	None	$ 140,482
Jennifer Ulmer	Asst. Administrator	None	85,101
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 225,583

B. Administrative - Other

Description	Amount
Other Contractual Costs (From County) for Security, Personnel, Purchasing & County Board [Detail on Schedule VIII]	$ 1,285,468
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,285,468

C. Professional Services

Vendor/Payee	Type	Amount
County Finance & A/P	Finance & AP	$ 70,583
County Auditor	Financial Auditing	5,886
County Acctg & Budget	Accounting	30,540
Other Misc	Cost Reprt & Acctg Srvcs	27,952
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 134,961

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,699
Unemployment Compensation Insurance	25,537
FICA Taxes	1,332,328
Employee Health Insurance	2,712,052
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	1,611,673
Workers Comp Claims	189,411
Other Contractual Benefit Expense	5,196
TOTAL (agree to Schedule V, line 22, col.8)	$ 5,898,896

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 60)	1,200
Life Srvcs Network	0
Joint Commission	1,070
Polaris Group	1,800
DuPage County Health Dept	1,400
Illinois Dept of Fin & Prof Regulatn	970
Various Other Amounts-per Sch	4,449
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,889

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,430
Seminar Expense	13,008
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,438

**See instructions.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2009 Ending: Nov. 30, 2010

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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? **NO**
If YES, give association name and amount. **Life Services Network = 0**

(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. $ **151,167** 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. $ **801,104**

(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? **N/A**
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 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.