FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0008201

Facility Name: Du Page Convalescent Center

Address: 400 North County Farm Road (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	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2010 to 11/30/2011 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) 3/22/2012 (Date)
(Type or Print Name) Beth Welch
(Title) Administrator

Paid Preparer
(Signed) 3/22/2012 (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

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: 12/01/2010 Ending: 11/30/2011

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 10/26/2011

	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)	368	180,380	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	368	180,380	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	90,843	14,368	9,839	115,050	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	90,843	14,368	9,839	115,050	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.78%

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 8,757

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 11/30/2011 Fiscal Year: YE 11/30/2011

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,620,605	134,277	2,487	1,757,369		1,757,369	(509,802)	1,247,567			1
2	Food Purchase		1,114,404		1,114,404		1,114,404	(323,282)	791,122			2
3	Housekeeping	1,330,888	247,865	56,194	1,634,947		1,634,947	(114,274)	1,520,673			3
4	Laundry	283,991	102,291	11,632	397,914		397,914	(1,831)	396,083			4
5	Heat and Other Utilities			1,639,780	1,639,780		1,639,780		1,639,780			5
6	Maintenance		14,144	1,153,355	1,167,499		1,167,499	37,183	1,204,682			6
7	Other (specify):*											7
8	**TOTAL General Services**	3,235,484	1,612,981	2,863,448	7,711,913		7,711,913	(912,006)	6,799,907			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	11,590,722	599,955	989,029	13,179,706	(867,033)	12,312,673		12,312,673			10
10a	Therapy	553,652	29,277	38	582,967	867,033	1,450,000		1,450,000			10a
11	Activities	427,013	8,658		435,671		435,671		435,671			11
12	Social Services	470,438	2,446	2,119	475,003		475,003		475,003			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	13,041,825	640,336	991,186	14,673,347		14,673,347		14,673,347			16
	C. General Administration											
17	Administrative	227,895		713,157	941,052		941,052	94,691	1,035,743			17
18	Directors Fees											18
19	Professional Services			123,390	123,390		123,390	9,738	133,128			19
20	Dues, Fees, Subscriptions & Promotions			204,385	204,385		204,385	(145,170)	59,215			20
21	Clerical & General Office Expenses	975,842	103,103	186,950	1,265,895		1,265,895	(27,370)	1,238,525			21
22	Employee Benefits & Payroll Taxes			6,439,678	6,439,678		6,439,678	157,476	6,597,154			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,738	13,738		13,738		13,738			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			237,921	237,921		237,921		237,921			26
27	Other (specify):*											27
28	**TOTAL General Administration**	1,203,737	103,103	7,919,219	9,226,059		9,226,059	89,365	9,315,424			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	17,481,046	2,356,420	11,773,853	31,611,319		31,611,319	(822,641)	30,788,678			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: 12/01/2010 Ending: 11/30/2011

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			1,184,645	1,184,645		1,184,645	(1,751)	1,182,894			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			132,757	132,757		132,757		132,757			35
36	Other (specify):*											36
37	TOTAL Ownership			1,317,402	1,317,402		1,317,402	(1,751)	1,315,651			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	448,710	2,404,934	35,413	2,889,057		2,889,057		2,889,057			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							270,570	270,570			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	448,710	2,404,934	35,413	2,889,057		2,889,057	270,570	3,159,627			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	17,929,756	4,761,354	13,126,668	35,817,778		35,817,778	(553,822)	35,263,956			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: 12/01/2010 Ending: 11/30/2011

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	(1,831)	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	(1,814)	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)**	$ (3,645)		$	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**	(550,177)	Pg 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (550,177)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (553,822)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule **Therapy**	X		867,033	10	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 867,033		47

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: 12/01/2010

Ending: 11/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cafeteria Income - Other Dietary Costs	$ (125,021)	1	1
2	Cafeteria Income - Food	(79,280)	2	2
3	421 Cafeteria Income - Other Dietary Costs	(384,781)	1	3
4	421 Cafeteria Income - Food	(244,002)	2	4
5	Other Misc Revenues	(25,556)	21	5
6	Overpayments and Refunds expense	(145,170)	20	6
7	West Campus Cleaning Revenue	(114,274)	3	7
8	Commissions for Vending	(78,679)	6	8
9	Indirect IMRF cost adjustment	1	22	9
10	Indirect FICA cost adjustment	8,928	22	10
11	Indirect Repairs expense adjustment	115,862	6	11
12	County Audit Expense	9,738	19	12
13	County Board Expense	19,520	17	13
14	County Treasurer Expense	67,842	17	14
15	County Clerk Expense	7,329	17	15
16	OPEB Expense	(3,850)	22	16
17	Additional IMRF Expense	152,397	22	17
18	Provider Participation Fee	270,570	42	18
19	Gain on Sale Of Capital Assets - Equipment	(1,751)	30	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**	(550,177)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center # 0008201 **Report Period Beginning:** 12/01/2010 **Ending:** 11/30/2011

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	(509,802)	0	0	0	0	0	0	0	0	0	0	(509,802)	1
2	Food Purchase	(323,282)	0	0	0	0	0	0	0	0	0	0	(323,282)	2
3	Housekeeping	(114,274)	0	0	0	0	0	0	0	0	0	0	(114,274)	3
4	Laundry	(1,831)	0	0	0	0	0	0	0	0	0	0	(1,831)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	37,183	0	0	0	0	0	0	0	0	0	0	37,183	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(912,006)	0	0	0	0	0	0	0	0	0	0	(912,006)	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	94,691	0	0	0	0	0	0	0	0	0	0	94,691	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	9,738	0	0	0	0	0	0	0	0	0	0	9,738	19
20	Fees, Subscriptions & Promotions	(145,170)	0	0	0	0	0	0	0	0	0	0	(145,170)	20
21	Clerical & General Office Expenses	(27,370)	0	0	0	0	0	0	0	0	0	0	(27,370)	21
22	Employee Benefits & Payroll Taxes	157,476	0	0	0	0	0	0	0	0	0	0	157,476	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**	89,365	0	0	0	0	0	0	0	0	0	0	89,365	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(822,641)	0	0	0	0	0	0	0	0	0	0	(822,641)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Du Page Convalescent Center** **# 0008201** **Report Period Beginning:** **12/01/2010** **Ending:** **11/30/2011**

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(1,751)	0	0	0	0	0	0	0	0	0	0	(1,751)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,751)	0	0	0	0	0	0	0	0	0	0	(1,751)	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	270,570	0	0	0	0	0	0	0	0	0	0	270,570	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	270,570	0	0	0	0	0	0	0	0	0	0	270,570	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(553,822)	0	0	0	0	0	0	0	0	0	0	(553,822)	45

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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
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: 12/01/2010 Ending: 11/30/2011

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 1/30/2011

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	28,159,090	2906	$ 28,159,090	$ 0	3,144,198	$ 3,144,198	1
2	19	Finance & AP	# of A/P Claims	42,165	179	614,266	318,952	4,621	67,319	2
3	19	County Audit	% of Time Spent	243,450	11	243,450	0	9,738	9,738	3
4	19	County Auditor Allocation	# of A/P Claims	41,397	178	66,168	40,837	4,621	7,386	4
5	19	General Acctg & Budget	% of All Depts	1,558,138	53	1,558,138	797,381	29,399	29,399	5
6	21	Mail Delivery	Wtd Avg # of Del	399,807	45	399,807	212,635	9,135	9,135	6
7	22	Workers Comp Claims	Direct Cost	2,552,216	2906	2,552,216	0	303,101	303,101	7
8	22	Workers Comp Premiums	# of FTEs / # of Clms	137,484	2906	137,484	0	17,862	17,862	8
9	26	Property Insurance	Building Value %	344,868	55	344,868	0	29,201	29,201	9
10	26	Auto Liability Claims	Direct Cost	76,555	0	76,555	0	952	952	10
11	26	General Liability Claims	Direct Cost	190,408	0	190,408	0	832	832	11
12	26	General Liability Premiums	FTE's/Direct Cost/# Vh	575,783	2906	575,783	0	171,114	171,114	12
13	26	Surety Bonds	Direct Cost	20,400	0	20,400	0	5,000	5,000	13
14	22	Unemployment Comp Claims	Direct Cost	201,715	0	201,715	0	14,734	14,734	14
15	22	Unemplymnt Comp Premiums	FTEs	8,035	2906	8,035	0	1,034	1,034	15
16	26	Service retention Fee	# of Ins Claims	181	25	94,554	0	59	30,821	16
17	5	Space Allocation	Square Footage	2,725,449	55	2,725,449	1,210,397	621,172	621,172	17
18	5	Power Plant	Square Footage	4,198,917	49	4,198,917	1,864,778	315,205	315,205	18
19	17	Security	Square Footage	1,290,860	55	1,290,860	670,499	329,658	329,658	19
20	6	Building Maintenance	Direct Cost	2,689,293	55	2,689,293	1,194,340	888,375	888,375	20
21	6	Rep/Mtc Rd/Signal/Drain Systm	Square Footage	836,241	50	836,241	399,420	115,862	115,862	21
22	35	Rental of Mach & Equipment	Direct Cost	13,217	0	13,217	0	1,522	1,522	22
23	6	Repair & Maint of DP Equip	Direct Cost	33,891	0	33,891	0	4,608	4,608	23
24		(Continued on Page 8A)								24
25	TOTALS					$ 47,030,805	$ 6,709,239		$ 6,118,228	25

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 1/30/2011

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	20	Statutory & Fiscal Charges	Direct Cost	20,884		$ 20,884	$	120	$ 120	1
2	17	Personnel Costs & Benfts Adm	FTEs	1,771,827	68	1,771,827	798,473	309,619	309,619	2
3	17	Purchasing Costs	# of Purchase Orders	875,261	109	875,261	442,989	73,880	73,880	3
4	17	County Board	Comm Assignments	923,648	49	923,648	923,648	19,520	19,520	4
5	17	County Treasurer	# of Checks	67,842	49	67,842		67,842	67,842	5
6	17	County Clerk	# of Related Orders	7,329	49	7,329		7,329	7,329	6
7	22	OPEB - Retirees Hlth Ins Exp	Direct Cost	(3,850)	2906	(3,850)		(3,850)	(3,850)	7
8	22	Additional IMRF Exp	Direct Cost	152,397	2906	152,397		152,397	152,397	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					$ 3,815,338	$ 2,165,110		$ 626,857	25

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 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: 12/01/2010 Ending: 11/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 2010 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 2010.

	(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	$	$

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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. [X] (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: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	288		1947	1,947	$ 70,858	$	30	$	$	$ 70,858	4
5	104			1978	4,456,548		30			4,456,548	5
6	16			1979	1,750,524		30			1,750,524	6
7				1983	1,172,064	34473	34	34,473		985,340	7
8	100			1993	6,516,821	233928	10/12/15/20	233,928		4,504,948	8
	Improvement Type**										
9	Mech room renovation & heat exchangers			1976	44,372		20			44,372	9
10	Alarm equip doors & other, Project 181			1977	8,545		20			8,545	10
11	Cyclone dust collector			1978	12,188		20			12,188	11
12	Flagpole			1979	844		20			844	12
13	Kitchen floor / Ground north remodel			1981	212,304		20			212,304	13
14	South Bldg renovation - Phase III (Per 1989 Adj)			1983	3,871,516		20			3,871,516	14
15	South Bldg renovation - Phase III Architect fees			1983	262,953		20			262,953	15
16	Laundry, 3-Center & Nurse station remodel			1985	91,792		15/20			91,792	16
17	Tubs & Parking lot projects			1989	199,883		20			199,883	17
18	Oxygen Manifold - North Bldg			1990	5,423	22	20	22		5,423	18
19	Ground North & Hydrotherapy remodel			1991	331,513	10,828	15/20/25	10,828		329,813	19
20	Window replacement, 3-Center & Nurse station remodel			1992	604,207	21,451	10/15/20/25	21,451		595,950	20
21	Laundry water heater & softners, asphalt rep & landscape			1993	588,826	22,107	10/12/15/20	22,107		544,641	21
22	ADA & Elevator upgrades, Nurse station remodel & misc			1994	105,577	3,250	5/10/15/20	3,250		97,323	22
23	Sewer Ejector pumps & Carpet replacement			1995	31,457		5/10			31,457	23
24	Carpet replace in Recreation & Volunteer areas & misc			1996	7,963		5			7,963	24
25	Chilled water bridges, Liquid oxygen, Lights refit & Elevtr			1997	320,587	13,103	5/10/20	13,103		246,130	25
26	Elevator Pit ladders & automatic entrance doors			1998	10,922	142	10/20	142		10,044	26
27	Lobby remodel, Carpet, Elevator safety system & HVAC			1999	701,043	3,210	5/10/20	3,210		676,065	27
28	Tubs, Receptn, Lndry, Kitchen Elev, HVAC & access eqp			2000	848,131	10,626	5/10/15/20	10,626		803,808	28
29	Tub rm remodel, Life safety syst, Elev & Liq Oxygen eqp			2001	473,208	45,801	10	45,801		473,208	29
30	Carpeting, incl North Day Room			2002	8,582		5			8,582	30
31	Roof rehab, Card readers & Kitchen renovation			2002	219,254	21,926	10	21,926		201,089	31
32	Fire Alarm Dampers, Fire System & Constructn Admin			2002	1,515,449	151,544	10	151,544		1,363,939	32
33	Director Signage			2002	65,448	3,273	20	3,273		29,724	33
34	HVAC Modifications			2002	102,341	6,822	15	6,822		61,404	34
35	Curtain Wall Installation			2003	13,140	876	15	876		7,373	35
36	Carpet Installation			2003	1,148		5			1,148	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 872	25	$ 872	$	$ 7,706	37
38	Curtain Wall Project	2003	338,936	33,894	10	33,894		273,974	38
39	Alarm System Prof Fees	2003	1,000		5			1,000	39
40	Fire Alarm System Replacement	2004	165,176	16,518	10	16,518		125,259	40
41	Hi-Res LW Light Camera	2004	2,768		5			2,768	41
42	Rekey Main Entrance & Door Contact Installation	2004	1,733		5			1,733	42
43	Pharmacy Storage Remodeling	2004	2,050	205	10	205		1,571	43
44	Reconfigure Front	2005	6,599	660	10	660		4,562	44
45	Commercial Carpet	2005	4,357	436	10	436		3,014	45
46	Air Handler CC	2005	75,447	7,545	10	7,545		49,670	46
47	New Door	2005	3,295		5			3,295	47
48	Wireless Exterior Gate	2005	12,010		5			12,010	48
49	Roof Top HVAC in Residents Dining Rm	2005	7,235	723	10	723		4,461	49
50	Floor Preparation	2005	721	72	10	72		487	50
51	North Entrance Badge Reader	2005	1,712		5			1,712	51
52	Wanderer System	2005	2,970		5			2,970	52
53	Relocate Card Reader - Door 4, Ground Floor	2005	2,704		5			2,704	53
54	Asst Administrators Office Carpet	2005	1,068		5			1,068	54
55	Fiber /PBX FON System	2005	2,842		5			2,842	55
56	Alarm Installation	2005	2,475	247	10	247		1,485	56
57	Door Repairs - 2 items	2005	8,463		5			8,463	57
58	Patch & Repair	2005	2,902		5			2,902	58
59	Fire Pump and Installation	2005	58,432	5,843	10	5,843		35,059	59
60	Steel Frame and Door	2006	2,136	214	5	214		2,136	60
61	Sidewalk Installation	2006	4,111	411	10	411		2,227	61
62	Laundry Room Lighting	2006	2,790	418	5	418		2,790	62
63	Locksmith - Lock Rekeyings (2)	2006	3,109	518	5	518		3,109	63
64	Laundry Room Lighting	2006	2,557	469	5	469		2,557	64
65	Parking Lot Painting	2006	291	53	5	53		291	65
66	HVAC Modifications	2006	1,802,424	90,121	20	90,121		450,606	66
67	Laundry Room Renovation	2006	701,152	70,116	10	70,116		350,576	67
68	Fire Pump Installation	2006	135,000	13,500	10	13,500		67,500	68
69									69
70	TOTAL (lines 4 thru 69)		$ 28,005,706	$ 826,217		$ 826,217	$	$ 23,400,206	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: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 826,217		$ 826,217	$	$ 23,400,206	1
2	Building Permit for Office Relocation	2009	5,230	261	20	261		719	2
3	Kitchen Roof Top Airhandler	2009	10,908	1,091	10	1,091		2,182	3
4	One East Dining Room Flooring	2009	9,664	967	10	967		1,933	4
5	Flooring Replacement for 3 - Center	2009	18,900	3,780	5	3,780		7,560	5
6	Transfer of Nurse Call System	2010	3,996	400	10	400		666	6
7	Carpet / Floor Tile Removal	2010	2,605	260	10	260		499	7
8	Fire Protection - Life Safety	2010	79,152	7,915	10	7,915		15,171	8
9	New Lobby Entrance	2010	18,992	1,899	10	1,899		3,640	9
10	Window Replacement	2010	115,487	11,549	10	11,549		22,135	10
11	Nurse Call System	2010	180,441	18,044	10	18,044		34,584	11
12	Roof Replacement	2010	13,500	900	15	900		1,725	12
13	Resident Dining Room Roof Replacement	2010	107,567	7,172	15	7,172		13,745	13
14	West Corridor Extension Project	2010	79,193	7,920	10	7,920		15,179	14
15	Lighting Study	2010	4,900	980	5	980		1,470	15
16	Elevator Card Reader Install	2010	1,844	369	5	369		492	16
17	Bldg Permit, East Hallway Renovation	2010	875	175	5	175		219	17
18	Eastwing Ground Floor Renovation	2010	92,414	4,621	20	4,621		5,006	18
19	South Building Renovation	2010	1,100,966	55,048	20	55,048		77,985	19
20	Building Needs Assessment	2010	20,121	4,024	5	4,024		4,024	20
21	Henry Hyde Marquee Sign	2010	29,225	2,922	10	2,922		2,922	21
22	1 North Day Room Remodeling	2010	8,382	838	10	838		838	22
23									23
24	Lavatory Sink in Volunteers Bathroom	2011	747	37	10	37		37	24
25	Hot Water Heater	2011	13,639	1,137	5	1,137		1,137	25
26	Upgrade of Fire System	2011	11,539	769	10	769		769	26
27	Medical Vacuum	2011	27,983	1,866	10	1,866		1,866	27
28	WI FI Installation	2011	4,007	467	5	467		467	28
29	Smoke Detectors and Equipment Installation	2011	15,916	796	10	796		796	29
30	Door Frame for Tub Room	2011	612	26	10	26		26	30
31	Carpeting	2011	4,134	276	5	276		276	31
32	Renovation of 4 Shower Floors	2011	62,904	2,097	10	2,097		2,097	32
33	Plumbing for Volunteer Office Bathroom	2011	6,215	155	10	155		155	33
34	TOTAL (lines 1 thru 33)		$ 30,057,764	$ 964,978		$ 964,978	$	$ 23,620,526	34

**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: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12B, Carried Forward		$ 30,057,764	$ 964,978		$ 964,978	$	$ 23,620,526	1
2	Fire Safety Material and Installation	2011	3,409		10				2
3	Roof Exhaust Supplies - East Wing	2011	5,004		10				3
4	Supply & Install Fire Rated Ceiling Tile	2011	3,512		10				4
5	Door Closures Fire Safe Replacements	2011	11,435		10				5
6	Driveway Replacement	2011	20,512		5				6
7	Replacement of Flooring	2011	12,808		5				7
8	Replacement Flooring	2011	10,700		5				8
9	Big Beam LED Exit Signs	2011	15,069		10				9
10	Wellness Center	2011	161,412		10				10
11	Shower Room Floors	2011	13,137		10				11
12									12
13									13
14	Unlocated - Depr Reconcile adj to TB / Rounding diff			359		359		2	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 30,314,762	$ 965,337		$ 965,337	$	$ 23,620,528	34

**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: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,031,180	$ 177,152	$ 177,152	$	5-15	$ 1,508,780	71
72	Current Year Purchases	343,147	17,157	17,157		5-10	17,157	72
73	Fully Depreciated Assets	2,873,375					2,873,375	73
74	Gain on Sale of FA			(1,751)	(1,751)			74
75	TOTALS	$ 5,247,702	$ 194,309	$ 192,558	$ (1,751)		$ 4,399,312	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	Various/97 Ford Van/Window	Various to 2002	$ 265,583	$ 3,140	$ 3,140	$	3/4/10	$ 265,582	76
77	Maint & Transport	Ford 2010 F250 Extended Van	2010	32,280	6,456	6,456		5	8,070	77
78	Maint & Transport	Ford 2010 F-550 Passngr van	2010	77,015	15,403	15,403		5	17,970	78
79	Maint & Transport	Extended Length Van	2011	31,300				5		79
80	TOTALS			$ 406,178	$ 24,999	$ 24,999	$		$ 291,622	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)	$ 36,763,002	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,184,645	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,182,894	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,751)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 28,311,462	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	$ 218,360	92
93			93
94			94
95		$ 218,360	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: 12/01/2010 Ending: 11/30/2011

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: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 132,757 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	N/A	N/A	$ N/A	$ N/A	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.

DuPage Convalescent Center **SCH. XII**

Year Ended 11/30/2011 State # 0008201 **Page 14A**

Equipment Rental Expense Summary

AC Number	Dept.	Per A601T23P	FY' 10 Accrual	FY' 11 Accrual	Refund	Reclass of Expense	(A) Per G/L
4500-3510	Administration	$ 49,920.55	$ (6,678.21)	$ -	$ -	$ (2,234.73)	**$ 41,007.61**
4501-3510	Nursing Admin	$ 50,443.26	$ (420.00)	$ -	$ -	$ -	**$ 50,023.26**
4504-3510	Business Office	$ -	$ -	$ -	$ -	$ -	**$ -**
4507-3510	Pharmacy	$ -	$ -	$ -	$ -	$ -	**$ -**
4509-3510	Clinical Support	$ 11,148.00	$ (1,162.00)	$ -	$ -	$ -	**$ 9,986.00**
4510-3510	Volunteer	$ -	$ -	$ -	$ -	$ -	**$ -**
4514-3510	Dietary	$ 4,948.35	$ (388.95)	$ -	$ -	$ -	**$ 4,559.40**
4516-3510	Housekeeping	$ -	$ -	$ -	$ -	$ -	**$ -**
4523-3510	1 East	$ 25,842.82	$ (184.30)	$ -	$ -	$ -	**$ 25,658.52**
4538-3510	Offsite Cafeteria	$ -	$ -	$ -	$ -	$ -	**$ -**
4599-3510	Indirect Cost All	$ -	$ -	$ 1,522.13	$ -	$ -	**$ 1,522.13**
		$ 142,302.98	$ (8,833.46)	$ 1,522.13	$ -	$ (2,234.73)	**$ 132,756.92**

(A) Note: This has been reclassified out, per F140T work papers, from these various departments 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 Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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	1785	hrs	65,624				1,785	65,624	4
5	Physician Care	Ln 10, Col 8		visits		9,090	33,000		9,090	33,000	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	Ln 39, Col 8	62475	# of prescrpts				2,404,933	62,475	2,404,933	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				$ 65,624	9,090	$ 33,000	$ 2,404,933	73,350	$ 2,503,557	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: 12/01/2010 Ending: 11/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (2,872,237)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500,000)	12,272,875		3
4	Supply Inventory (priced at)	395,112		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)**	$ 9,795,750	$	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	30,314,760		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,336,565		16
17	Accumulated Depreciation (book methods)	(28,311,462)		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	218,360		22
23	Other(specify):	317,315		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,659,898	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 18,455,648	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,269,628	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,727,259		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	2,258,329		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,255,216	$	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	1,558,511		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,558,511	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,813,727	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,641,921	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 18,455,648	$	48

***(See instructions.)**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,956,972	1
2	Restatements (describe):		2
3	**Adjustment to Capital Contributions**	(263,602)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,693,370	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,329,414)	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)**	$ (1,329,414)	17
	B. Transfers (Itemize):		
18	**Capital Contributions**	5,277,965	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 5,277,965	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,641,921	24 *

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	$ 27,345,178	1
2	Discounts and Allowances for all Levels	(3,125,697)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 24,219,481	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,211,597	6
7	Oxygen	10,951	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,222,548	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,718,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	833,084	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,232,645	17
18	Sale of Supplies to Non-Patients	25,556	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,831	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,811,116	23
	D. Non-Operating Revenue		
24	Contributions	39,853	24
25	Interest and Other Investment Income***	602	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 40,455	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	West Campus Cleaning Revenue	114,274	28
28a	Misc. Other - Vending / Loss on Sale of FA	80,490	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 194,764	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 34,488,364	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	7,711,913	31
32	Health Care	14,673,347	32
33	General Administration	9,226,059	33
	B. Capital Expense		
34	Ownership	1,317,402	34
	C. Ancillary Expense		
35	Special Cost Centers	2,889,057	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)***	$ 35,817,778	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,329,414)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,329,414)	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.**

Breakdown of Other Revenue
Schedule XVII Line 28 and 28a.

Account	Description	Amount	Ref.
4353	West Campus Cleaning Revenue	**$ 114,274**	Line 28
6502	Commissions Telephone & Vending	$ 78,679	
6601	Accounts Receivable Write Off Recovery	$ 60	
4901	Gain on Disposal of Fixed Assets	$ 1,751	
	Total Other	**$ 80,490**	Line 28a

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,751	2,060	$ 120,047	$ 58.28	1
2	Assistant Director of Nursing	3,329	4,198	181,506	43.24	2
3	Registered Nurses	118,643	136,597	4,353,299	31.87	3
4	Licensed Practical Nurses	38,834	43,931	1,148,954	26.15	4
5	CNAs & Orderlies	315,099	362,635	5,335,664	14.71	5
6	CNA Trainees					6
7	Licensed Therapist	1,750	1,992	65,624	32.94	7
8	Rehab/Therapy Aides	22,253	25,702	412,086	16.03	8
9	Activity Director	3,661	4,296	107,453	25.01	9
10	Activity Assistants	16,766	19,558	319,560	16.34	10
11	Social Service Workers	18,802	22,578	470,438	20.84	11
12	Dietician	6,257	7,197	160,687	22.33	12
13	Food Service Supervisor	9,734	11,084	337,265	30.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,195	23,832	344,657	14.46	15
16	Dishwashers	75,038	81,920	777,997	9.50	16
17	Maintenance Workers					17
18	Housekeepers	96,645	111,775	1,330,888	11.91	18
19	Laundry	22,647	25,793	283,991	11.01	19
20	Administrator	1,591	1,881	136,546	72.59	20
21	Assistant Administrator	1,628	1,881	91,349	48.56	21
22	Other Administrative	15,339	17,768	354,804	19.97	22
23	Office Manager					23
24	Clerical	21,847	26,114	613,642	23.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,743	1,992	83,338	41.84	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,542	4,878	96,550	19.79	31
32	Other Health Ca Nsg Sect/WC	17,923	20,692	354,701	17.14	32
33	Other(specify) Ancill Srvcs	14,683	16,894	448,710	26.56	33
34	TOTAL (lines 1 - 33)	850,700	977,248	$ 17,929,756 *	$ 18.35	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	8,528	399,442	Ln 10, C3	40
41	Occupational Therapy Consultant	4,506	211,036	Ln 10, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5,477	256,555	Ln 10, C3	43
44	Activity Consultant				44
45	Social Service Consultant	20	1,300	Ln 12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	18,531	$ 868,333		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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: 12/01/2010 Ending: 11/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Beth Welch	Administrator	None	$ 136,546
Jennifer Ulmer	Asst. Administrator	None	91,349
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 227,895

B. Administrative - Other

Description	Amount
Personnel Dept. Expense (From County)	$ 309,619
Purchasing Dept. Expenses	73,880
Security Dept. Expense	329,658
[Detail on Schedule VIII]	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 713,157

C. Professional Services

Vendor/Payee	Type	Amount
County Finance & A/P	Finance & AP	$ 67,319
County Auditor Services	Auditor Allocation	7,386
County Acctg & Budget	Gen. Accounting / Budget	29,399
Other Financial Services	Cost Reprt & Acctg Srvcs	15,505
Tech / Data Proc Srvcs	Data Processing / IT	3,781
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 123,390

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 17,862
Unemployment Compensation Insurance	15,769
FICA Taxes	1,342,549
Employee Health Insurance	2,951,711
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	1,954,046
Workers Comp Claims	303,101
Other Contractual Benefit Expense	12,116
TOTAL (agree to Schedule V, line 22, col.8)	$ 6,597,154

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,568
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 440)	8,816
Life Srvcs Network	30,976
Joint Commission	1,285
Polaris Group	1,800
DuPage County Health Dept	2,250
City of Wheaton	2,723
Various Other Amounts-per Sch	4,797
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 59,215

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,945
Seminar Expense	11,793
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,738

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Life Services Network = $30,976**

(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. $ **149,989** 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. $ **270,570**
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. $ **833,084**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Wolf & Company, CPA's**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees