		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

County: Du Page

Telephone Number: (630) 665-6400 **Fax #** (630) 784-4203

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 Dec. 1, 2011 to Nov. 30, 2012 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) 3/27/2013 (Date)
(Type or Print Name) Jennifer Ulmer
(Title) Interim Administrator

Paid Preparer

(Signed) 3/27/2013 (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: Dec. 1, 2011 Ending: Nov. 30, 2012

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	368	Skilled (SNF)	368	134,688	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	368	TOTALS	368	134,688	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	88,942	18,727	9,363	117,032	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	88,942	18,727	9,363	117,032	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.89%

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 8,396

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 11/30/2012 Fiscal Year: YE 11/30/2012

* 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, 2011 Ending: Nov. 30, 2012

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	1,662,924	116,114	2,320	1,781,358		1,781,358	(485,064)	1,296,294			1
2	Food Purchase		1,155,880		1,155,880		1,155,880	(314,746)	841,134			2
3	Housekeeping	1,209,769	137,492	45,450	1,392,711		1,392,711	(54,650)	1,338,061			3
4	Laundry	302,291	103,954	8,521	414,766		414,766	4,781	419,547			4
5	Heat and Other Utilities			1,463,911	1,463,911		1,463,911		1,463,911			5
6	Maintenance		92,587	877,884	970,471		970,471	(504)	969,967			6
7	Other (specify):*											7
8	**TOTAL General Services**	3,174,984	1,606,027	2,398,086	7,179,097		7,179,097	(850,183)	6,328,914			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	11,664,953	662,600	1,123,219	13,450,772	(1,005,768)	12,445,004		12,445,004			10
10a	Therapy	567,841	40,413	116	608,370		608,370		608,370			10a
11	Activities	486,138	6,717	78	492,933		492,933		492,933			11
12	Social Services	440,714	996	1,560	443,270		443,270		443,270			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	13,159,646	710,726	1,124,973	14,995,345	(1,005,768)	13,989,577		13,989,577			16
	C. General Administration											
17	Administrative	234,120		727,151	961,271		961,271	94,491	1,055,762			17
18	Directors Fees											18
19	Professional Services			156,349	156,349		156,349	10,272	166,621			19
20	Dues, Fees, Subscriptions & Promotions			247,186	247,186		247,186	(207,519)	39,667			20
21	Clerical & General Office Expenses	976,289	102,595	320,384	1,399,268		1,399,268	(23,335)	1,375,933			21
22	Employee Benefits & Payroll Taxes			6,945,465	6,945,465		6,945,465	(40,344)	6,905,121			22
23	Inservice Training & Education											23
24	Travel and Seminar			59,599	59,599		59,599		59,599			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			780,318	780,318		780,318		780,318			26
27	Other (specify):*											27
28	**TOTAL General Administration**	1,210,409	102,595	9,236,452	10,549,456		10,549,456	(166,435)	10,383,021			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	17,545,039	2,419,348	12,759,511	32,723,898	(1,005,768)	31,718,130	(1,016,618)	30,701,512			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, 2011 Ending: Nov. 30, 2012

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			1,206,307	1,206,307		1,206,307		1,206,307			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			169,163	169,163		169,163		169,163			35
36	Other (specify):*											36
37	TOTAL Ownership			1,375,470	1,375,470		1,375,470		1,375,470			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	448,815	2,294,755	8,508	2,752,078	1,005,768	3,757,846		3,757,846			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							202,032	202,032			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	448,815	2,294,755	8,508	2,752,078	1,005,768	3,757,846	202,032	3,959,878			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	17,993,854	4,714,103	14,143,489	36,851,446		36,851,446	(814,586)	36,036,860			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, 2011 Ending: Nov. 30, 2012

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	4,781	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	(7,885)	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)**	$ (3,104)		$	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**	(811,482)	Pg 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (811,482)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (814,586)		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		1,005,768	10	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,005,768		47

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: Dec. 1, 2011

Ending: Nov. 30, 2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cafeteria Income - Other Dietary Costs	$ (153,459)	1	1
2	Cafeteria Income - Food Costs	(99,575)	2	2
3	421 Cafeteria Income - Other Dietary Costs	(331,605)	1	3
4	421 Cafeteria Income - Food	(215,171)	2	4
5	Other Misc Revenues	(15,450)	21	5
6	Overpayments and Refunds expense	(207,519)	20	6
7	West Campus Cleaning Revenue	(54,650)	3	7
8	Commissions for Vending	(100,102)	6	8
9	Provider Participation Fee	202,032	42	9
10	Indirect FICA cost adjustment	(40,344)	22	10
11	County Audit Expense	10,272	19	11
12	Indirect Repairs expense adjustment	99,598	6	12
13	County Board Expense	19,320	17	13
14	County Treasurer Expense	67,842	17	14
15	County Clerk Expense	7,329	17	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(811,482)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: Nov. 30, 2012

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	(485,064)	0	0	0	0	0	0	0	0	0	0	(485,064)	1
2	Food Purchase	(314,746)	0	0	0	0	0	0	0	0	0	0	(314,746)	2
3	Housekeeping	(54,650)	0	0	0	0	0	0	0	0	0	0	(54,650)	3
4	Laundry	4,781	0	0	0	0	0	0	0	0	0	0	4,781	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(504)	0	0	0	0	0	0	0	0	0	0	(504)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(850,183)	0	0	0	0	0	0	0	0	0	0	(850,183)	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	94,491	0	0	0	0	0	0	0	0	0	0	94,491	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	10,272	0	0	0	0	0	0	0	0	0	0	10,272	19
20	Fees, Subscriptions & Promotions	(207,519)	0	0	0	0	0	0	0	0	0	0	(207,519)	20
21	Clerical & General Office Expenses	(23,335)	0	0	0	0	0	0	0	0	0	0	(23,335)	21
22	Employee Benefits & Payroll Taxes	(40,344)	0	0	0	0	0	0	0	0	0	0	(40,344)	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**	(166,435)	0	0	0	0	0	0	0	0	0	0	(166,435)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,016,618)	0	0	0	0	0	0	0	0	0	0	(1,016,618)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Du Page Convalescent Center # 0008201 **Report Period Beginning:** Dec. 1, 2011 **Ending:** Nov. 30, 2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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	202,032	0	0	0	0	0	0	0	0	0	0	202,032	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	202,032	0	0	0	0	0	0	0	0	0	0	202,032	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(814,586)	0	0	0	0	0	0	0	0	0	0	(814,586)	45

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: Nov. 30, 2012

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DuPage County	100.00	None		N/A		
(DuPage Convalescent Center is						
a subunit of DuPage County. See						
Sch. VIII for Allocations of costs						
from the County.)						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [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	$	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, 2011 Ending: Nov. 30, 2012

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: Dec. 1, 2011 Ending: ov. 30, 2012

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

	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	29,419,824	0	$ 29,419,824	$ 0	3,397,444	$ 3,397,444	1
2	19	Finance & AP	# of A/P Claims	40,906	176	638,392	315,661	4,681	73,053	2
3	19	County Audit	% of Time Spent	256,790	11	256,790	0	10,272	10,272	3
4	19	County Auditor Allocation	# of A/P Claims	40,114	175	88,299	39,959	4,681	10,304	4
5	19	General Acctg & Budget	% of All Depts	1,583,204	53	1,583,204	782,706	29,872	29,872	5
6	21	Mail Delivery	Wtd Avg # of Del	424,540	45	424,540	209,852	9,679	9,679	6
7	22	Workers Comp Claims	Direct Cost	1,915,042	0	1,915,042	0	259,223	259,223	7
8	22	Workers Comp Premiums	# of FTEs / # of Clms	161,801	2850	161,801	0	22,441	22,441	8
9	26	Property Insurance	Building Value %	324,920	53	324,920	0	27,992	27,992	9
10	26	Auto Liability Claims	Direct Cost	634,272	0	634,272	0	527,425	527,425	10
11	26	General Liability Claims	Direct Cost	71,208	0	71,208	0	16,785	16,785	11
12	26	General Liability Premiums	FTE's/Direct Cost/#Vh	521,763	2850	521,763	0	147,079	147,079	12
13	26	Surety Bonds	Direct Cost	20,865	0	20,865	0	5,000	5,000	13
14	22	Unemployment Comp Claims	Direct Cost	262,366	0	262,366	0	47,161	47,161	14
15	22	Unemplymnt Comp Premiums	FTEs	8,247	2850	8,247	0	1,105	1,105	15
16	26	Service retention Fee	# of Ins Claims	180	25	176,959	0	57	56,037	16
17	19	Ins Broker/Consultnt Fees	FTEs	140,700	2850	140,700	0	18,464	18,464	17
18	5	Space Allocation	Square Footage	2,636,129	53	2,636,129	1,254,305	583,099	583,099	18
19	5	Power Plant	Square Footage	4,099,105	50	4,099,105	1,950,408	291,071	291,071	19
20	17	Security	Square Footage	1,220,989	64	1,220,989	686,895	325,058	325,058	20
21	6	Building Maintenance	Direct Cost	2,569,554	0	2,569,554	1,222,628	822,735	822,735	21
22	6	Rep/Mtc Rd/Signal/Drain Systm	Square Footage	717,636	60	717,636	348,389	99,598	99,598	22
23	35	Rental of Mach & Equipment	Direct Cost	22,265	0	22,265	0	11,685	11,685	23
24		(Continued on Page 8A)								24
25	TOTALS					$ 47,914,870	$ 6,810,803		$ 6,792,582	25

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: ov. 30, 2012

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: DuPage County Government
Street Address: 421 N. County Farm Road (Finance Dept)
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	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	6	Repair & Maint of DP Equip	Direct Cost	42,532		$ 42,532	$	5,114	$ 5,114	1
2	20	Statutory & Fiscal Charges	Direct Cost	559,268		559,268		1,642	1,642	2
3	17	Personnel Costs & Benfts Adm	FTEs	1,648,098	64	1,648,098	719,335	317,832	317,832	3
4	17	Purchasing Costs	# of Purchase Orders	927,022	97	927,022	458,212	84,262	84,262	4
5	17	County Board	Comm Assignments	894,704	48	894,704	894,704	19,320	19,320	5
6	17	County Treasurer	# of Checks	67,842	48	67,842		67,842	67,842	6
7	17	County Clerk	# of Related Orders	7,329	48	7,329		7,329	7,329	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					$ 4,146,795	$ 2,072,251		$ 503,341	25

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: Nov. 30, 2012

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: Dec. 1, 2011 Ending: Nov. 30, 2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - No Real Estate Tax paid on County Home		$	$
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: Nov. 30, 2012

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: Dec. 1, 2011 Ending: Nov. 30, 2012

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	148		1947	1979	$ 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	34472	34	34,472		1,019,812	7
8	100			1993	6,516,821	233928	10/12/15/20	233,928		4,738,876	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		20			5,423	18
19	Ground North & Hydrotherapy remodel			1991	331,513	1,051	15/20/25	1,051		330,864	19
20	Window replacement, 3-Center & Nurse station remodel			1992	604,207	7,821	10/15/20/25	7,821		603,771	20
21	Laundry water heater & softners, asphalt rep & landscape			1993	588,825	22,106	10/12/15/20	22,106		566,747	21
22	ADA & Elevator upgrades, Nurse station remodel & misc			1994	105,577	3,249	5/10/15/20	3,249		100,572	22
23	Sewer Ejector pumps & Carpet replacement			1995	35,064		5/10			35,064	23
24	Carpet replace in Recreation & Volunteer areas & misc			1996	4,356		5			4,356	24
25	Chilled water bridges, Liquid oxygen, Lights refit & Elevtr			1997	320,587	13,104	5/10/20	13,104		259,234	25
26	Elevator Pit ladders & automatic entrance doors			1998	10,922	143	10/20	143		10,187	26
27	Lobby remodel, Carpet, Elevator safety system & HVAC			1999	701,043	3,209	5/10/20	3,209		679,274	27
28	Tubs, Receptn, Lndry, Kitchen Elev, HVAC & access eqp			2000	832,461	10,627	5/10/15/20	10,627		798,766	28
29	Tub rm remodel, Life safety syst, Elev & Liq Oxygen eqp			2001	473,208		10			473,208	29
30	Fire Alarm System, Roof, HVAC and various other			2002	1,911,073	179,769	5/10/15/20	179,769		1,844,507	30
31	Curtain Wall, Fencing and other assets			2003	376,034	35,642	5/10/15/25	35,642		326,843	31
32	Fire Alarm System Replacement and other assets			2004	182,683	17,818	5/10	17,818		156,728	32
33	Air Handler CC, Fire Pump Install and various other assets			2005	182,276	14,431	5/10	14,431		143,559	33
34	HVAC Modifications, Laundry Rm Renovatn & various other			2006	2,653,570	174,147	5/10/20	174,147		1,055,940	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: Nov. 30, 2012

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	Building Permit for Office Relocation	2009	$ 5,230	$ 261	20	$ 261	$	$ 981	37
38	Kitchen Roof Top Airhandler	2009	10,908	1,091	10	1,091		3,272	38
39	One East Dining Room Flooring	2009	9,664	966	10	966		2,899	39
40	Flooring Replacement for 3 - Center	2009	18,900	3,780	5	3,780		11,340	40
41	Carpet / Floor Tile Removal	2009	2,605	261	10	261		760	41
42	Fire Protection - Life Safety	2009	79,152	7,915	10	7,915		23,086	42
43	New Lobby Entrance	2009	18,992	1,899	10	1,899		5,539	43
44	Window Replacement	2009	115,487	11,549	10	11,549		33,684	44
45	Nurse Call System	2009	180,441	18,044	10	18,044		52,628	45
46	Roof Replacement	2009	13,500	900	15	900		2,625	46
47	Resident Dining Room Roof Replacement	2009	107,567	7,171	15	7,171		20,916	47
48	West Corridor Extension Project	2009	79,193	7,919	10	7,919		23,098	48
49									49
50	Transfer of Nurse Call System	2010	3,996	400	10	400		1,066	50
51	Lighting Study	2010	4,900	980	5	980		2,450	51
52	South Building Renovation	2010	1,100,966	55,048	20	55,048		133,033	52
53	Elevator Card Reader Install	2010	1,844	369	5	369		861	53
54	Bldg Permit, East Hallway Renovation	2010	875	175	5	175		394	54
55	Eastwing Ground Floor Renovation	2010	92,414	4,621	20	4,621		9,626	55
56	Building Needs Assessment	2010	20,121	4,024	5	4,024		8,048	56
57	Henry Hyde Marquee Sign	2010	29,225	2,922	10	2,922		5,845	57
58	1 North Day Room Remodeling	2010	8,382	838	10	838		1,676	58
59									59
60	Upgrade of Fire System	2011	11,539	1,154	10	1,154		1,923	60
61	Medical Vacuum	2011	27,983	2,798	10	2,798		4,664	61
62	WI FI Installation	2011	4,007	801	5	801		1,269	62
63	Lavatory Sink in Volunteers Bathroom	2011	747	75	10	75		112	63
64	Smoke Detectors and Equipment Installation	2011	15,916	1,592	10	1,592		2,387	64
65	Hot Water Heater	2011	13,639	2,728	5	2,728		3,864	65
66	Door Frame for Tub Room	2011	612	61	10	61		87	66
67	Carpeting	2011	4,134	827	5	827		1,102	67
68	Renovation of 4 Shower Floors	2011	62,904	6,290	10	6,290		8,387	68
69	Plumbing for Volunteer Office Bathroom	2011	6,215	621	10	621		777	69
70	TOTAL (lines 4 thru 69)		$ 30,042,092	$ 899,597		$ 899,597	$	$ 24,504,457	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, 2011 Ending: Nov. 30, 2012

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		$ 30,042,092	$ 899,597		$ 899,597	$	$ 24,504,457	1
2	Fire Safety Material and Installation	2011	3,409	341	10	341		341	2
3	Roof Exhaust Supplies - East Wing	2011	5,004	500	10	500		500	3
4	Supply & Install Fire Rated Ceiling Tile	2011	3,512	351	10	351		351	4
5	Door Closures Fire Safe Replacements	2011	11,435	1,143	10	1,143		1,143	5
6	Driveway Replacement	2011	20,512	4,102	5	4,102		4,102	6
7	Replacement of Flooring	2011	12,808	2,562	5	2,562		2,562	7
8	Replacement Flooring	2011	10,700	2,140	5	2,140		2,140	8
9	Big Beam LED Exit Signs	2011	15,069	1,507	10	1,507		1,507	9
10	Wellness Center	2011	161,412	16,141	10	16,141		16,141	10
11	Shower Room Floors	2011	13,137	1,314	10	1,314		1,314	11
12									12
13	Window Replacement	2012	5,915	986	5	986		986	13
14	Flooring Install - North Day Rms	2012	10,919	1,274	5	1,274		1,274	14
15	Cabling for Resident TVs	2012	65,956	4,397	5	4,397		4,397	15
16	Furnish/Install Pipes, Hot Water System	2012	30,063	1,503	5	1,503		1,503	16
17	Material/ Install Laundry Barco Joints	2012	8,027	67	10	67		67	17
18	Dayroom Survey Documents	2012	19,945	166	10	166		166	18
19	Wellness Center Flooring	2012	14,698		5				19
20	Roof Repair and Roof Walk Installation	2012	51,079		10				20
21	Flooring Projects	2012	28,994		5				21
22	Resident Dining Rm Flooring	2012	52,255		5				22
23	Cable Install for Wireless Access	2012	75,762		5				23
24	Barco Joints - Laundry Rm	2012	6,568		10				24
25	Window Replacement Project	2012	20,549		10				25
26									26
27	Unlocated - Depr Reconcile adj to TB / Rounding diff		(1)	2		2			27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 30,689,819	$ 938,093		$ 938,093	$	$ 24,542,951	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: Dec. 1, 2011 Ending: Nov. 30, 2012

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	$ 2,205,369	$ 238,929	$ 238,929	$	5-15	$ 1,595,907	71
72	Current Year Purchases	38,677	1,166	1,166		5-10	1,166	72
73	Fully Depreciated Assets	3,017,044					3,017,044	73
74								74
75	TOTALS	$ 5,261,090	$ 240,095	$ 240,095	$		$ 4,614,117	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Snowplow & Maint/02 Van	Var-97 Ford Van/Window Van	Var to '85-02	$ 265,583	$	$	$	3/4/10	$ 265,583	76
77	Maint & Transport	Ford 2010 F250 Extended Van	2010	32,280	6,456	6,456		5	14,526	77
78	Maint & Transport	Ford 2010 F-550 Passngr van	2010	77,015	15,403	15,403		5	33,373	78
79	Maint & Transport	Extended Length Van	2011	31,300	6,260	6,260		5	6,260	79
80	TOTALS			$ 406,178	$ 28,119	$ 28,119	$		$ 319,742	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)	$ 37,151,447	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,206,307	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,206,307	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 29,476,810	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	$ 201,184	92
93			93
94			94
95		$ 201,184	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, 2011 Ending: Nov. 30, 201

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 169,163 Description: Facility Medical and Office Equipment (See Pg 14A Attached)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	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.

AC Number	Dept.	Per A601T23P	FY 2011 Accrual Reversal	FY' 12 Accrual	Refund	Reallocation of Expense	(A) Per G/L
4500-3510	Administration	$ 44,072.69	$ -	$ -	$ -	$ -	**$ 44,072.69**
4501-3510	Nursing Admin	$ 53,984.88	$ -	$ -	$ -	$ -	**$ 53,984.88**
4504-3510	Business Office	$ -	$ -	$ -	$ -	$ -	**$ -**
4507-3510	Pharmacy	$ -	$ -	$ -	$ -	$ -	**$ -**
4509-3510	Clinical Support	$ 14,319.00	$ -	$ -	$ -	$ -	**$ 14,319.00**
4510-3510	Volunteer	$ -	$ -	$ -	$ -	$ -	**$ -**
4514-3510	Dietary	$ 4,619.40	$ -	$ -	$ -	$ -	**$ 4,619.40**
4516-3510	Housekeeping	$ -	$ -	$ -	$ -	$ -	**$ -**
4523-3510	1 East	$ 40,481.98	$ -	$ -	$ -	$ -	**$ 40,481.98**
4538-3510	Offsite Cafeteria	$ -	$ -	$ -	$ -	$ -	**$ -**
4599-3510	Indirect Cost All	$ 11,685.00	$ -	$ -	$ -	$ -	**$ 11,685.00**
		#########	$ -	$ -	$ -	$ -	**$ 169,162.95**

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: Nov. 30, 201

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 that were 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: Dec. 1, 2011 Ending: Nov. 30, 2012

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	1702	hrs	67,700				1,702	67,700	4
5	Physician Care	Ln 10, Col 8		visits		10,743	39,000		10,743	39,000	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	Ln 39, Col 8	57188	# of prescrpts				2,248,817	57,188	2,248,817	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				$ 67,700	10,743	$ 39,000	$ 2,248,817	69,633	$ 2,355,517	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, 2011 Ending: Nov. 30, 2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of Nov. 30, 2012 (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	$ 2,370,917	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500,000)	5,635,909		3
4	Supply Inventory (priced at)	361,142		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)**	$ 8,367,968	$	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	30,689,819		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,349,953		16
17	Accumulated Depreciation (book methods)	(29,476,810)		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	201,184		22
23	Other(specify): Capital Lease	317,315		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,865,821	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,233,789	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,177,115	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,016,683		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	Accrued PTO and Other Liab	3,020,905		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,214,703	$	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 - LT	1,384,028		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,384,028	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,598,731	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,635,058	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,233,789	$	48

***(See instructions.)**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: Nov. 30, 201

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,641,921	1	
2	Restatements (describe):		2	
3	**Adjustment to Capital Contributions during Yr**	(412,150)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,229,771	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(5,363,888)	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) **Rounding Difference**	(1)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (5,363,889)	17	
	B. Transfers (Itemize):			
18	**Capital Contributions at YE**	3,769,176	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 3,769,176	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,635,058	24	*

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: Nov. 30, 2012

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 32,432,409	1
2	Discounts and Allowances for all Levels	(10,842,209)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 21,590,200	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	39,181	5
6	Therapy	3,357,248	6
7	Oxygen	61,317	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,457,746	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,400,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	799,810	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,020,816	17
18	Sale of Supplies to Non-Patients	15,450	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	(4,781)	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,231,295	23
	D. Non-Operating Revenue		
24	Contributions	44,716	24
25	Interest and Other Investment Income***	8,713	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53,429	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**West Campus Cleaning Revenue**	54,650	28
28a	**Other - Vending $100102 / AR Write Offs $136**	100,238	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 154,888	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 31,487,558	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	7,179,097	31
32	Health Care	14,995,345	32
33	General Administration	10,549,456	33
	B. Capital Expense		
34	Ownership	1,375,470	34
	C. Ancillary Expense		
35	Special Cost Centers	2,752,078	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)***	$ 36,851,446	40
41	**Income before Income Taxes (line 30 minus line 40)****	(5,363,888)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (5,363,888)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 15,144,572	44
45	Private Pay - Net Inpatient Revenue	2,084,764	45
46	Medicare - Net Inpatient Revenue	4,360,864	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 21,590,200	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: Nov. 30, 2012

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	1,729	2,091	$ 123,704	$ 59.16	1
2	Assistant Director of Nursing	3,504	4,906	212,192	43.25	2
3	Registered Nurses	122,964	141,749	4,562,679	32.19	3
4	Licensed Practical Nurses	33,699	38,129	979,958	25.70	4
5	CNAs & Orderlies	317,904	364,758	5,329,275	14.61	5
6	CNA Trainees					6
7	Licensed Therapist	1,702	2,030	67,700	33.35	7
8	Rehab/Therapy Aides	20,987	25,441	414,034	16.27	8
9	Activity Director	5,412	6,441	157,059	24.38	9
10	Activity Assistants	16,607	21,093	329,079	15.60	10
11	Social Service Workers	18,338	21,274	440,714	20.72	11
12	Dietician	6,227	7,520	170,620	22.69	12
13	Food Service Supervisor	9,445	10,861	334,880	30.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,656	24,048	342,155	14.23	15
16	Dishwashers	76,193	83,028	815,268	9.82	16
17	Maintenance Workers					17
18	Housekeepers	92,713	104,393	1,209,769	11.59	18
19	Laundry	23,396	27,675	302,291	10.92	19
20	Administrator	1,680	1,910	141,008	73.83	20
21	Assistant Administrator	1,593	1,889	93,112	49.29	21
22	Other Administrative	15,966	18,203	360,379	19.80	22
23	Office Manager					23
24	Clerical	24,073	28,235	615,910	21.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,690	2,030	86,108	42.42	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,544	4,060	80,576	19.85	31
32	Other Health Ca Nsg Sect/WC	18,398	21,686	376,569	17.36	32
33	Other(specify) Ancill Srvcs	14,921	17,037	448,815	26.34	33
34	TOTAL (lines 1 - 33)	854,341	980,487	$ 17,993,854 *	$ 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	9,003	467,112	Ln 10, C3	40
41	Occupational Therapy Consultant	5,777	299,710	Ln 10, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4,713	244,492	Ln 10, C3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,560	Ln 12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	19,517	$ 1,012,874		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: Dec. 1, 2011 Ending: Nov. 30, 2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Beth Welch	Administrator	None	$ 141,008
Jennifer Ulmer	Asst. Administrator	None	93,112
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 234,120

B. Administrative - Other

Description	Amount
Personnel Dept. Expense (From County)	$ 317,832
Purchasing Dept. Expenses (From Cnty)	84,261
Security Dept. Expense (From Cnty)	325,058
[Detail on Schedule VIII]	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 727,151

C. Professional Services

Vendor/Payee	Type	Amount
County Finance & A/P	Finance & AP	$ 73,053
County Auditor Services	Auditor Allocation (Col 3)	10,304
County Acctg & Budget	Gen. Accounting / Budget	29,872
Other Financial Services	Cost Reprt & Acctg Srvcs	18,898
Tech / Data Proc Srvcs	Data Processing / IT	24,222
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 156,349

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,441
Unemployment Compensation Insurance	48,266
FICA Taxes	1,347,008
Employee Health Insurance	3,163,826
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	2,050,436
Workers Comp Claims	259,223
Other Contractual Benefit Expense	13,921
TOTAL (agree to Schedule V, line 22, col.8)	$ 6,905,121

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	$ 2,250
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,128
(Indicate # of checks performed)	
Life Srvcs Network	22,701
Joint Commission	4,500
Polaris Group	1,800
Robin Technologies	2,500
County Nrsg Home Assoc	1,550
Various Other Amounts	3,357
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,786

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,845
Seminar Expense	57,754
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 59,599

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2011 Ending: Nov. 30, 2012

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: Dec. 1, 2011 Ending: Nov. 30, 20

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. **LSN $22,701 /Cty Nsg Home Assoc $1550**

(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. $ **165,650** 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. $ **202,032**
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. $ **799,810**

(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