FOR BHF USE

LL1

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: DuPage

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

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1935

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: Raj Shah, Sr. Reimb. Consultant **Telephone Number:** (630) 530-7100 Ext 107
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 12/01/2013 to 11/30/2014 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) _____ (Date)
(Type or Print Name) Jennifer Ulmer
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Raj Shah, Senior Reimbursement Consultant
(Firm Name & Address) Strategic Reimubrsement Group LLC, 360 West Buttlerfield Road, Suite 310, Elmhurst, IL 60126
(Telephone) (630) 530-7100 Ext 107 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: 12/01/2013 Ending: 11/30/2014

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	134,320	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	368	TOTALS	368	134,320	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	74,855	33,663	8,481	116,999	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	74,855	33,663	8,481	116,999	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.10%

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 Laundary

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 368 and days of care provided 7,507

Medicare Intermediary Wisconsin Physician Services (WPS)

IV. ACCOUNTING BASIS

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

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

Tax Year: 11/30/2014 Fiscal Year: 11/30/2014

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2013 Ending: 11/30/2014

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	1,694,155	125,603	29,265	1,849,023		1,849,023		1,849,023			1
2	Food Purchase		1,227,712		1,227,712		1,227,712	(780,031)	447,681			2
3	Housekeeping	1,202,203	164,573	56,353	1,423,129		1,423,129	(3,101)	1,420,028			3
4	Laundry	264,320	117,157	11,078	392,555		392,555	(1,680)	390,875			4
5	Heat and Other Utilities			760,130	760,130		760,130	1,476,579	2,236,709			5
6	Maintenance		9,706	2,149	11,855		11,855	5,473	17,328			6
7	Other (specify):*											7
8	TOTAL General Services	3,160,678	1,644,751	858,975	5,664,404		5,664,404	697,240	6,361,644			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	12,388,827	629,908	1,388,143	14,406,878		14,406,878		14,406,878			10
10a	Therapy	534,759	28,710	4,637	568,106		568,106		568,106			10a
11	Activities	445,811	11,384	2,380	459,575		459,575		459,575			11
12	Social Services	364,347	1,576	8,487	374,410		374,410		374,410			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	13,733,744	671,578	1,403,647	15,808,969		15,808,969		15,808,969			16
	C. General Administration											
17	Administrative	544,030	60,323	204,749	809,102		809,102	833,205	1,642,307			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	632,827	18,098	156,340	807,265		807,265		807,265			21
22	Employee Benefits & Payroll Taxes			6,964,842	6,964,842		6,964,842	347,745	7,312,587			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							12,354	12,354			26
27	Other (specify):*											27
28	TOTAL General Administration	1,176,857	78,421	7,325,931	8,581,209		8,581,209	1,193,304	9,774,513			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	18,071,279	2,394,750	9,588,553	30,054,582		30,054,582	1,890,544	31,945,126			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: 12/01/2013 Ending: 11/30/2014

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			901,601	901,601		901,601		901,601			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							1,181	1,181			35
36	Other (specify):*											36
37	**TOTAL Ownership**			901,601	901,601		901,601	1,181	902,782			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	451,990	2,266,568	118,799	2,837,357		2,837,357	(16,490)	2,820,867			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							860,221	860,221			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	451,990	2,266,568	118,799	2,837,357		2,837,357	843,731	3,681,088			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	18,523,269	4,661,318	10,608,953	33,793,540		33,793,540	2,735,456	36,528,996			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: 12/01/2013 Ending: 11/30/2014

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				8
9	Non-Straightline Depreciation	(1,680)	4		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				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)**	$ (1,680)		$	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 **Page 5A Total**	2,737,136		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,737,136		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 2,735,456		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: 12/01/2013

Ending: 11/30/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cafeteria Income	$ (780,031)	2	1
2	campus cleaning svc income	(3,101)	3	2
3	misc revenue	(29,723)	17	3
4	refunds and overpayments	(46,005)	17	4
5	telephone vending comm.	(27,152)	17	5
6	other reimb.	(195,762)	17	6
7	Wellness Center Income	(16,490)	39	7
8	Provider Participation Fees Exp	860,221	42	8
9	Service fee income	(23,418)	17	9
10				10
11	DuPage County Cost Alloc.- heating and Other Utilities	1,476,579	5	11
12	DuPage County Cost Alloc.-Equip repair/maint.	5,473	6	12
13	DuPage County Cost Alloc.- administration	1,155,265	17	13
14	DuPage County Cost Alloc.- employee benefits	347,745	22	14
15	DuPage County Cost Alloc.- Prof. liability ins.	12,354	26	15
16	DuPage County Cost Alloc.- Equipment lease	1,181	35	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**	2,737,136		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center **#** 0008201 **Report Period Beginning:** 12/01/2013 **Ending:** 11/30/2014

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(780,031)	0	0	0	0	0	0	0	0	0	0	(780,031)	2
3	Housekeeping	(3,101)	0	0	0	0	0	0	0	0	0	0	(3,101)	3
4	Laundry	(1,680)	0	0	0	0	0	0	0	0	0	0	(1,680)	4
5	Heat and Other Utilities	1,476,579	0	0	0	0	0	0	0	0	0	0	1,476,579	5
6	Maintenance	5,473	0	0	0	0	0	0	0	0	0	0	5,473	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	697,240	0	0	0	0	0	0	0	0	0	0	697,240	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	833,205	0	0	0	0	0	0	0	0	0	0	833,205	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	347,745	0	0	0	0	0	0	0	0	0	0	347,745	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	12,354	0	0	0	0	0	0	0	0	0	0	12,354	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	1,193,304	0	0	0	0	0	0	0	0	0	0	1,193,304	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	1,890,544	0	0	0	0	0	0	0	0	0	0	1,890,544	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Du Page Convalescent Center **#** 0008201 **Report Period Beginning:** 12/01/2013 **Ending:** 11/30/2014

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	1,181	0	0	0	0	0	0	0	0	0	0	1,181	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,181	0	0	0	0	0	0	0	0	0	0	1,181	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	(16,490)	0	0	0	0	0	0	0	0	0	0	(16,490)	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	860,221	0	0	0	0	0	0	0	0	0	0	860,221	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	843,731	0	0	0	0	0	0	0	0	0	0	843,731	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,735,456	0	0	0	0	0	0	0	0	0	0	2,735,456	45

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2013 Ending: 11/30/2014

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			None		
(DuPage Convalescent Center is a						
subunit of DuPage County. See						
Sch. VIII for the allocation 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: 12/01/2013 Ending: 11/30/2014

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: 12/01/2013 Ending: 1/30/2014

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 , Il 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						$	$		$	1
2	Please refer to Page 8-1 for the details									2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

DuPage Convalescent Center
Provider Number: 14-5050
FYE: 11/30/2014
Allocation of Indirect Cost
Attachment to Schedule VIII - Allocation of Indirect Cost

Sum of FY 2014 TOTAL				
Sch V Ln No	Sch V Ln No Description	Paid To:	Acct Description	Total
5	Heat and Other Utilities	01-700 Facilities Mgmt - Utilities	Heating & Cooling Services	-
	Heat and other utilities	01-700 Facilities Mgmt-Power Plant (FY14 All FM-not incl utilities)	Repair & Mtce Facilities	1,476,579
5 Total				1,476,579
6	Maintenance	01-700 Facilities Mgmt - Bldg Mtce	(blank)	-
		01-700 Facilities Mgmt - Space	(blank)	-
		01-798 Spec Accts	Repair & Mtce Other Equipment	5,473
6 Total				5,473
17	Administrative	01-500 County Auditor	Auditing & Accounting Services	57,137
		01-750 Personnel	Other Contractual Expenses	316,980
		01-751 Personnel-Security	Security Services	338,081
		01-760 Finance A/P	Auditing & Accounting Services	95,406
		01-760 Finance-Gen Acct/Budgeting	Auditing & Accounting Services	24,951
		01-760 Finance-Mailroom	Postage & Postal Charges	7,054
		01-760 Finance-Purchasing	Other Professional Services	59,428
		01-796 Corporate Fund Ins	Property Insurance	30,515
		01-798 Spec Accts	Miscellaneous Meeting Expense	-
			Other Contractual Expenses	4,784
			Other Professional Services	-
			Statutory & Fiscal Charges	40
			(blank)	-
		07-797 Liability Insurance	Auto Liability Insurance	-
			Public Liability Insurance	196,358
			Service Retention Program	19,532
			Surety Bonds	5,000
17 Total				1,155,265
22	Employee Benefits & Payroll Tax	01-750 Personnel-Tuition Rmb	Tuition Reimbursement	-
		01-796 Flex Benefit Rmb	Flexible Benefit Earnings	-
		01-796 Medical Insurance	Employee Med & Hosp Insurance	-
		01-798 Spec Accts	Benefit Payments	-
		06-794 I.M.R.F.	Employer Share I.M.R.F.	-
		07-797 Liability Insurance	Unemployment Comp Insurance	18,101
			Workers Compensation Insurance	329,644
		08-790 Social Security	Employer Share Social Security	-
22 Total				347,745
26	Prof. Liability Ins	07-797 Liability Insurance	Other Professional Services	12,354
26 Total				12,354
35	Rent - Equip and Vehicle	01-760 Finance - Pager Rental	Rental Of Machinery & Equipmnt	1,181
35 Total				1,181
Grand Total				2,998,597

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2013 Ending: 11/30/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	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:** 12/01/2013 **Ending:** 11/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:		
	2009	8
	2010	9
	2011	10
	2012	11
	2013	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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.**

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Du Page Convalescent Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0008201

CONTACT PERSON REGARDING THIS REPORT Raj Shah

TELEPHONE (630) 530-7100 Ext 107 FAX #: (630) 530-7106

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - No R.E. 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 12/01/2013 Ending: 11/30/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 257,371 B. General Construction Type: Exterior Masonary Rough Conc 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 DuPage County Government (Parent Organization) offices and buildings are next to and across county farm road from DuPage 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:

3. Current Period Amortization: N/A 4. Dates Incurred:

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: 12/01/2013 Ending: 11/30/2014

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	104			1978	$ 4,456,549	$	30	$	$	$ 4,456,549	4
5	148		1947	1979	70,858		5			70,858	5
6	16			1979	1,750,524		30			1,750,524	6
7				1983	1,172,064	2,944	34	2,944		1,092,563	7
8	100			1993	6,462,934	6,663		6,663		5,005,541	8
	Improvement Type**										
9	Remodel and HVAC			1976	44,372	-	20	-		44,372	9
10	ALARM EQUIP.-DOORS, ETC. PROJ.			1977	8,545	-	20	-		8,545	10
11	ELECTRIC MOTOR CYCLONE DUST CO			1978	12,188	-	20	-		12,188	11
12	ALUMINUM FLAGPOLE			1979	844	-	20	-		844	12
13	NORTH WING GROUND FLOOR REMOLD			1981	212,304	-	20	-		212,304	13
14	PHASE III-BLDG.COMM. SOUTH BLD			1983	4,134,469	-	20	-		4,134,469	14
15	NEW SOLARIUM 3RD FLR. CENTRAL			1985	91,792	-	17	-		91,792	15
16	Remodel and HVAC			1989	199,883	-	20	-		199,883	16
17	OXYGEN MANIFOLD NO. BLDG. (INS			1990	5,423	-	20	-		5,423	17
18	Plumbing and HVAC			1991	331,513	14	19	14		331,200	18
19	Remodel, HVAC and Electrical			1992	604,208	9	18	9		603,984	19
20	Remodel and Plumbing			1993	642,712	-	14	-		642,712	20
21	Remodel, HVAC and Electrical			1994	105,577	-	15	-		105,577	21
22	Remodel and Plumbing			1995	35,064	-	8	-		35,064	22
23	Carpeting			1996	4,356	-	5	-		4,356	23
24	Remodel, HVAC and Electrical			1997	320,587	1,117	16	1,117		286,862	24
25	UNTAGABLE AUTOMATIC DOOR NORTH and Garage + Elevator Instal.			1998	10,922	12	13	12		10,487	25
26	Roof, Remodel and HVAC Work			1999	701,043	271	12	271		686,011	26
27	Roof, Remodel, Plumbing, and HVAC Work			2000	832,461	923	12	923		821,395	27
28	Remodel, plubming and electrical work			2001	473,208	-	10	-		473,208	28
29	Roof, Remodel and HVAC Work			2002	1,911,073	856	10	856		1,865,731	29
30	Alarm system, carpet and curtain wall instal.			2003	376,034	147	12	147		361,577	30
31	Carpet, alarm replacement, andr remodel.			2004	182,683	-	8	-		182,683	31
32	Remodel and HVAC			2005	182,276	1,267	7	1,267		174,464	32
33	Remodel and HVAC			2006	2,653,570	14,761	8	14,761		1,421,980	33
34											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: 12/01/2013 Ending: 11/30/2014

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	ONE EAST DINING ROOM FLOORING	2009	$ 9,664	$ 82	10	$ 82	$	$ 4,927	37
38	BUILDING PERMIT FOR OFFICE REL	2009	5,230	22	20	22		1,527	38
39	ROOF REPLACEMENT	2009	13,500	76	15	76		4,507	39
40	WEST CORRIDOR EXTENSION PROJEC	2009	79,193	669	10	669		39,716	40
41	RESIDENT DINING ROOM ROOF REPL	2009	107,567	602	15	602		35,914	41
42	WINDOW REPLACEMENT	2009	115,487	976	10	976		57,917	42
43	NEW LOBBY ENTRANCE	2009	18,992	160	10	160		9,525	43
44	CARPET/FLOOR TILE REMOVAL	2009	2,605	22	10	22		1,306	44
45	KITCHEN ROOF TOP AIRHANDLER	2009	10,908	92	10	92		5,562	45
46	NURSE CALL SYSTEM	2009	180,441	1,525	10	1,525		90,492	46
47	FIRE PROTECTION - LIFE SAFETY	2009	79,152	669	10	669		39,695	47
48	FLOORING REPLACEMENT, 3-CENTER	2009	18,900	-	5	-		18,900	48
49									49
50	SOUTH BUILDING RENOVATION	2010	1,100,966	4,611	20	4,611		248,019	50
51	EASTWING GROUND FLOOR RENOVATI	2010	92,414	387	20	387		19,278	51
52	1 NORTH DAY ROOM REMODELING	2010	8,382	71	10	71		3,434	52
53	ELEVATOR CARD READER INSTALLAT	2010	1,844	32	5	32		1,650	53
54	HENRY HYDE - MARQUEE SIGN	2010	29,225	246	10	246		11,972	54
55	LIGHTING STUDY	2010	4,900	86	5	86		4,554	55
56	BUILDING NEEDS ASSESSENT	2010	20,121	350	5	350		16,621	56
57	BUILDING PERMIT, EAST HALLWAY	2010	875	15	5	15		768	57
58	TRANSFER OF NURSE CALL SYSTEM	2010	3,996	34	10	34		1,904	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		**$ 29,894,398**	**$ 39,711**		**$ 39,711**	**$**	**$ 25,711,332**	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: 12/01/2013 Ending: 11/30/2014

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		$ 29,894,398	$ 39,711		$ 39,711	$	$ 25,711,332	1
2	ROOF EXHAUST SUPPLIES - EAST W	2011	5,004	42	10	42		1,549	2
3	WELLNESS CENTER	2011	161,412	1,359	10	1,359		49,953	3
4	REPLACEMENT FLOORING	2011	10,700	183	5	183		6,665	4
5	REPLACEMENT OF FLOORING	2011	12,808	220	5	220		7,978	5
6	CARPETING	2011	4,134	71	5	71		2,854	6
7	SHOWER ROOM FLOORS	2011	13,137	111	10	111		4,065	7
8	PLUMBING FOR VOLUNTEER OFFICE	2011	6,215	52	10	52		2,079	8
9	RENOVATION OF 4 SHOWER FLOORS	2011	62,904	530	10	530		21,567	9
10	HOT WATER HEATER	2011	13,639	235	5	235		9,646	10
11	LAVATORY SINK IN BATHROOM	2011	747	6	10	6		268	11
12	WIFI INSTALLATION	2011	4,007	69	5	69		2,969	12
13	BIG BEAM LED EXIT SIGNS	2011	15,069	127	10	127		4,664	13
14	DRIVEWAY REPLACEMENT	2011	20,512	352	5	352		12,776	14
15	DOORS/DOOR CLOSURES REPLCEMNTS	2011	11,435	96	10	96		3,539	15
16	SUPPLY & INSTALL FIRE RATED CE	2011	3,512	30	10	30		1,087	16
17	FIRE SAFETY MATERIAL & INSTALL	2011	3,409	29	10	29		1,055	17
18	DOOR & FRAME FOR TUB ROOM	2011	612	5	10	5		215	18
19	SMOKE DECTECTORS & EQUIPMENT I	2011	15,916	134	10	134		5,723	19
20	MEDICAL VACUUM	2011	27,983	236	10	236		10,528	20
21	UPGRADE OF FIRE SYSTEM	2011	11,539	97	10	97		4,342	21
22									22
23	ROOF REPAIR & ROOF WALK INSTAL	2012	51,079	430	10	430		10,693	23
24	WINDOW REPLACEMENT	2012	20,549	173	10	173		4,302	24
25	VARIOUS FLOORING PROJECTS	2012	28,994	494	5	494		12,214	25
26	WELLNESS CENTER FLOORING	2012	14,698	250	5	250		6,192	26
27	DAYROOM SURVEY DOCUMENTS	2012	19,945	168	10	168		4,342	27
28	WINDOW REPLACMENT	2012	5,915	101	5	101		3,485	28
29	RESIDENT DINING ROOM FLOORING	2012	52,255	889	5	889		22,014	29
30	BARCO JOINTS	2012	6,568	55	10	55		1,375	30
31	CABLE INSTALLATION FOR WIRELES	2012	75,762	1,290	5	1,290		31,917	31
32	MAT./INSTALL LAUNDRY BARCO JOI	2012	8,027	68	10	68		1,747	32
33	FURNISH/INST PIPES, HOT WATER	2012	30,063	512	5	512		14,177	33
34	**TOTAL (lines 1 thru 33)**		**$ 30,612,946**	**$ 48,125**		**$ 48,125**	**$**	**$ 25,977,311**	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: 12/01/2013 Ending: 11/30/2014

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		$ 30,612,946	$ 48,125		$ 48,125	$	$ 25,977,311	1
2	CABLING FOR RESIDENTS TV'S	2012	65,956	1,125	5	1,125		32,211	2
3	FLOORING INSTALLATION - NORTH	2012	10,919	187	5	187		5,883	3
4									4
5	TIMBER ROOF TERRACE REPLACE	2013	68,616	577	10	577		7,496	5
6	WELLNESS CENTER SECURITY ADD	2013	4,400	37	10	37		481	6
7	WELLNESS CENTER RENOVATION	2013	68,211	573	10	573		7,452	7
8	REPLACEMENT FLOORING	2013	26,686	224	10	224		2,915	8
9	NURSE CALL SYSTEM	2013	79,067	1,340	5	1,340		17,422	9
10	SMOKER'S SHELTER	2013	3,835	65	5	65		1,294	10
11	FURNISH & INSTALL HANDRAILS	2013	16,600	140	10	140		3,060	11
12	FURNISH/INSTALL HANDRAILS STAI	2013	10,000	170	5	170		3,878	12
13									13
14	Induction Air Terminal Replace	2014	4,840	40	10	40		121	14
15	Nurse Call Sys-Rayland Respond	2014	76,082	634	10	634		4,438	15
16	Replace Flring Various Locatio	2014	39,241	327	10	327		3,270	16
17									17
18	December 2014 depreciation in the fixed asset register							(67,004)	18
19	(Note : not claimed on FY14 cost report.)								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)**		$ 31,087,399	$ 53,564		$ 53,564	$	$ 26,000,226	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: 12/01/2013 Ending: 11/30/2014

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	$ 691,967	$ 10,415	$ 10,415	$	10	$ 485,997	71
72	Current Year Purchases	30,917	515	515		5	1,451	72
73	Fully Depreciated Assets	4,471,746	64	64		11	4,471,746	73
74								74
75	TOTALS	$ 5,194,630	$ 10,994	$ 10,994	$		$ 4,959,194	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	snow plow maint/Vans	97 paratransit/89 chevy	1989-2001	$ 112,026	$	$	$	8	$ 112,026	76
77	Maint and Transport	Ford F250 2010	2010	32,280	565	565		5	28,326	77
78	Maint and Transport	Ford F250 2010	2010	77,015	1,345	1,345		5	66,257	78
79	Maint and Transport	Extended Length Van 2011	2011	31,300	537	537		5	19,495	79
80	TOTALS			$ 252,621	$ 2,447	$ 2,447	$		$ 226,104	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)	$ 37,329,010	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 67,005	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 67,005	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)	$ 31,185,524	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	CIP	$ 791,840	92
93			93
94			94
95		$ 791,840	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: 12/01/2013 Ending: 11/30/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 159,603 Description: Please Refer to PG14A for the details.
(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
Medicaid Provider Number: 0008201
FYE: 11/30/2014
Medicaid CR - Page 14A - Equipment Rental Expenses Summary

Revenue & Expenses 3.

Account	Acct Unit	Per	FY' 13	FY' 134	Refund	Reallocation	Per G/L
2000-53410 (4501-3510)	Administration	$ 52,935.27	$ -	$ -	$ -	$ -	**$ 52,935.27**
2050-53410 (4501-3510)	Nursing Admin	$ 79,586.89	$ -	$ -	$ -	$ -	**$ 79,586.89**
2075-53410 (4509-3510)	Clinical Support	$ 13,534.60	$ -	$ -	$ -	$ -	**$ 13,534.60**
4510-3510	Volunteer	$ -	$ -	$ -	$ -	$ -	**$ -**
2025-53410 (4514-3510)	Dietary	$ 5,979.00	$ -	$ -	$ -	$ -	**$ 5,979.00**
4516-3510	Housekeeping	$ -	$ -	$ -	$ -	$ -	**$ -**
2055-53410 (4523-3510)	1 East	$ 7,501.07	$ -	$ -	$ -	$ -	**$ 7,501.07**
2100-53410 (4538-3510)	Offsite Cafeteria	$ 66.00	$ -	$ -	$ -	$ -	**$ 66.00**
2020-53410 (4599-3510)	Indirect Cost All	$ -	$ -	$ -	$ -	$ -	**$ -**
		$ 159,602.83	$ -	$ -	$ -	$ -	**$ 159,602.83**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2013 Ending: 11/30/2014

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.

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: 12/01/2013 Ending: 11/30/2014

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist			hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist			hrs							4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	LN 39, COL 8	63481	# of prescrpts	451,990			1,782,449	63,481	2,234,439	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				$ 451,990		$	$ 1,782,449	63,481	$ 2,234,439	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.

STATE OF ILLINOIS

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2013 Ending: 11/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (1,653,540)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500,000)	9,624,535		3
4	Supply Inventory (priced at)	362,000		4
5	Short-Term Investments	810,320		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to Govt & general fund	(993,574)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,149,741	$	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	31,087,397		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,447,253		16
17	Accumulated Depreciation (book methods)	(31,185,524)		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 (specify):	791,840		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,925,326	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,075,067	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 721,329	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,291,921		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	due to Govt. and other liabilities	3,222,061		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,235,311	$	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 vacation time	1,356,458		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,356,458	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,591,769	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,483,298	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,075,067	$	48

***(See instructions.)**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2013 Ending: 11/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,728,671	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,728,671	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	298,293	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)**	$ 298,293	17	
	B. Transfers (Itemize):			
18	**Net Contribution from general fund**	1,456,334	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,456,334	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 8,483,298	24	*

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2013 Ending: 11/30/2014

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	$ 42,147,655	1
2	Discounts and Allowances for all Levels	(14,430,769)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 27,716,886	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	746,580	14
15	Telephone, Television and Radio	27,152	15
16	Rental of Facility Space		16
17	Sale of Drugs	2,392,633	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	361,480	21
22	Laundry	1,680	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,929,525	23
	D. Non-Operating Revenue		
24	Contributions	96,512	24
25	Interest and Other Investment Income***	2,045	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 98,557	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Pl refer to PG19A for the details	346,865	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 346,865	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 34,091,833	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	5,664,404	31
32	Health Care	15,808,969	32
33	General Administration	8,581,209	33
	B. Capital Expense		
34	Ownership	901,601	34
	C. Ancillary Expense		
35	Special Cost Centers	2,837,357	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)***	$ 33,793,540	40
41	**Income before Income Taxes (line 30 minus line 40)****	298,293	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 298,293	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,730,715	44
45	Private Pay - Net Inpatient Revenue	12,382,306	45
46	Medicare - Net Inpatient Revenue	2,603,865	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 27,716,886	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.**

DuPage Convalesccent Center
Provider Number: 14-5050
FYE: 11/30/2014
Non Operating Revenue
Source: Trial Balance #2 from Wolf and Companny
Medciaid Cost Report - Page 19A Other Operating Revenue

Sum of 11/30/20142		Category		
Acct	Acct Description	Non Op Rev	Reported Separetly On Page 19	Other Non Op Rev
42000	SERVICE FEE	23,418		23,418
42080	WELLNESS CENTER FEE	16,490		16,490
42081	CONVO CAFETERIA EARNINGS	235,059	(235,059)	-
42082	JTK CAFETERIA EARNINGS	263,254	(263,254)	-
42083	JOF CAFETERIA EARNINGS	160,783	(160,783)	-
42085	CATERING SERVICE EARNINGS	87,484	(87,484)	-
42086	VENDING MACHINE EARNINGS	33,451	-	33,451
42087	CAMPUS CLEANING SERVICE FEE	3,101		3,101
42088	LAUNDRY SERVICE REIMB FEE	1,680	(1,680)	-
45000	INVESTMENT INCOME	2,045	(2,045)	-
46000	MISCELLANEOUS REVENUE	29,723		29,723
46006	REFUNDS AND OVERPAYMENTS	46,005		46,005
46007	TELEPHONE VENDING COMMISSIONS	27,152	(27,152)	-
46030	Pharmacy Reimb. For Non Patient related Svc	195,762		195,762
47000	TRANSFER IN GENERAL FUND	2,400,000	(2,400,000)	-
47106	GAIN ON SALE OF ASSETS	475		475
47200	Capital Contribution	96,512	(96,512)	-
	Suspense acct	(1,560)		(1,560)
(blank)				
Grand Total		3,620,834	(3,273,969)	346,865

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2013 Ending: 11/30/2014

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	1,791	2,084	$ 128,309	$ 61.57	1
2	Assistant Director of Nursing	3,610	4,168	154,190	36.99	2
3	Registered Nurses	94,408	107,536	3,365,466	31.30	3
4	Licensed Practical Nurses	33,532	38,332	978,077	25.52	4
5	CNAs & Orderlies	298,278	344,780	5,241,245	15.20	5
6	CNA Trainees					6
7	Licensed Therapist	1,492	1,858	64,488	34.71	7
8	Rehab/Therapy Aides	37,708	43,536	762,007	17.50	8
9	Activity Director	1,776	2,071	66,890	32.30	9
10	Activity Assistants	18,401	21,030	349,963	16.64	10
11	Social Service Workers	11,439	13,935	322,155	23.12	11
12	Dietician	1,836	2,085	57,179	27.42	12
13	Food Service Supervisor	7,372	9,187	197,812	21.53	13
14	Head Cook	12,785	15,293	252,206	16.49	14
15	Cook Helpers/Assistants	80,700	86,759	868,837	10.01	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	87,049	99,313	1,185,406	11.94	18
19	Laundry	22,446	27,034	289,588	10.71	19
20	Administrator	1,966	2,252	149,118	66.22	20
21	Assistant Administrator	3,933	4,592	214,923	46.80	21
22	Other Administrative	101,210	119,272	3,052,905	25.60	22
23	Office Manager					23
24	Clerical	13,182	16,529	319,727	19.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,653	4,211	82,775	19.66	31
32	Other Health Care(specify)					32
33	Other(specify) Pharmacy	12,064	13,918	420,003	30.18	33
34	TOTAL (lines 1 - 33)	850,631	979,775	$ 18,523,269 *	$ 18.91	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	240	36,000	Ln 10 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	240	$ 36,000		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: 12/01/2013 Ending: 11/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Ulmer	Administrator	None	$ 148,534
Support Staff	Support Staff	None	395,496
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 544,030

B. Administrative - Other

Description	Amount
Please refer to Page 21B for the details	$ 204,749
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 204,749

C. Professional Services

Vendor/Payee	Type	Amount
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	1,381,876
Employee Health Insurance	3,449,185
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	2,133,781
Pleaeser refer to PG21A for IMRF Contribution Rate Notice.	
TOTAL (agree to Schedule V, line 22, col.8)	$ 6,964,842

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Service Network	19,964
Dept of Public Health	3,980
DuPage County Health Dept.	2,250
Illinois State Poice	6,800
Polaris Group	1,907
Various Other Acccounts	3,926
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,827

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,760
Seminar Expense	63,813
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 67,573

* Attach copy of IMRF notifications

**See instructions.

Preliminary Notice of Illinois Municipal Retirement Fund Contribution Rate for Calendar Year 2014

Date April 2013

Employer name DUPAGE COUNTY Employer No. 02999

The IMRF Board of Trustees adopted an optional phase-in plan for 2014 employer contribution rates. Shown below are member contribution rates and 2014 employer contribution rates. Your preliminary 2014 IMRF ARC Contributions rate(s) are based on the actuarially calculated annual required contribution (ARC). The Optional Phase-in Contribution rate(s) are based upon the Board's optional phase-in plan.

IMRF ARC Contribution Rates

	Regular	SLEP	ECO
Member Contributions (tax-deferred)	4.50%	7.50%	7.50%
Employer Contributions			
• **Retirement Rate**			
Normal Cost	6.39%	12.64%	17.60%
Funding Adjustment <over> under	4.95%	10.83%	54.65%
Net Retirement Rate	11.34%	23.47%	72.25%
• **Other Program Benefits**			
Death	0.16%	0.16%	0.18%
Disability	0.11%	0.11%	0.11%
Supplemental Benefit Payment	0.62%	0.62%	0.62%
Early Retirement Incentive	0.00%	0.00%	0.00%
• **TOTAL EMPLOYER RATE**	12.23%	25.49%	73.16%

Below are the 2014 optional phase-in rate(s):

IMRF Optional Phase-in Contribution Rates

	Regular	SLEP	ECO
TOTAL EMPLOYER RATE	**N/A**	**N/A**	**60.75%**

You may select the ARC, the optional phase-in employer rate, or a rate between the two. If you do not provide us with your selection by August 31, 2013, we will assume you have chosen the optional phase-in rate. This rate will be reflected on your 'Final Notice of Illinois Municipal Retirement Fund Contribution Rate for Calendar Year 2014,' which will be available in Novermber 2013.

Attachment to Schedule XIX(B) - Other Administrative Cost

Account	Description	Amount	State CR Ln No	State CR Ln Description	State CR Columnn
2000-54110-0	EQUIPMENT AND MACHINERY	-	17.00	Administrative	3-Other Exp
2000-53830-0	OTHER CONTRACTUAL EXPENSES	1,998	17.00	Administrative	3-Other Exp
2000-53808-0	STATUTORY & FISCAL CHARGES	150	17.00	Administrative	3-Other Exp
2000-53804-0	POSTAGE & POSTAL CHARGES	9,544	17.00	Administrative	3-Other Exp
2000-53800-0	PRINTING	123	17.00	Administrative	3-Other Exp
2000-53610-0	INSTRUCTION & SCHOOLING	53,953	17.00	Administrative	3-Other Exp
2000-53600-0	DUES & MEMBERSHIPS	21,571	17.00	Administrative	3-Other Exp
2000-53510-0	TRAVEL EXPENSE	975	17.00	Administrative	3-Other Exp
2000-53410-0	RENTAL OF MACHINERY & EQUIPMNT	52,935	17.00	Administrative	3-Other Exp
2000-53260-0	WIRELESS COMMUNICATION SVC	7,362	17.00	Administrative	3-Other Exp
2000-53250-0	WIRED COMMUNICATION SERVICES	15,994	17.00	Administrative	3-Other Exp
2000-53090-0	OTHER PROFESSIONAL SERVICES	20,494	17.00	Administrative	3-Other Exp
2000-53020-0	INFORMATION TECHNOLOGY SVC	17,730	17.00	Administrative	3-Other Exp
2000-51050-0	FLEXIBLE BENEFIT EARNINGS	1,920	17.00	Administrative	3-Other Exp
	Total Admin-Other Cost	204,749			

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2013 Ending: 11/30/2014

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			$		$	$	$	$	$	$	$	$	$
2	N/A												
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: 12/01/2013 Ending: 11/30/2014

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 Service Network $19,664**

(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? _____

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,906** Line **10**

(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. $ **860,021**
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. $ **780,031**

(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**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees