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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: Deb Freeland **Telephone Number:** 317-569-6230
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 12/01/2015 to 11/30/2016 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) Deborah Freeland, Principal
(Firm Name & Address) CliftonLarsonAllen LLP, 9365 Counselors Row, Suite 200, Indianapolis, IN 46240
(Telephone) 317-569-6230 Fax # 317-574-9707

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: 12/01/2015 Ending: 11/30/2016

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 _____

	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	93,029	16,591	7,857	117,477	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	93,029	16,591	7,857	117,477	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.22%

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 6,336

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 11/30/16 Fiscal Year: 11/30/16

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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	1,733,849	121,561	11,824	1,867,234		1,867,234		1,867,234			1
2	Food Purchase		1,199,639		1,199,639		1,199,639	(773,362)	426,277			2
3	Housekeeping	1,131,856	137,211	51,709	1,320,776		1,320,776	(194,444)	1,126,332			3
4	Laundry	330,110	124,431	2,267	456,808		456,808		456,808			4
5	Heat and Other Utilities			675,997	675,997		675,997	1,189,904	1,865,901			5
6	Maintenance		17,995	27,143	45,138		45,138	105,084	150,222			6
7	Other (specify):*											7
8	TOTAL General Services	3,195,815	1,600,837	768,940	5,565,592		5,565,592	327,182	5,892,774			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	11,775,071	332,547	2,152,125	14,259,743		14,259,743		14,259,743			10
10a	Therapy	596,043	26,290	1,839	624,172	(200,921)	423,251		423,251			10a
11	Activities	473,919	3,213	157	477,289		477,289		477,289			11
12	Social Services	517,603	4,838	5,226	527,667		527,667		527,667			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	13,362,636	366,888	2,159,347	15,888,871	(200,921)	15,687,950		15,687,950			16
	C. General Administration											
17	Administrative	619,896	60,082	103,317	783,295	(20,530)	762,765	1,481,098	2,243,863			17
18	Directors Fees											18
19	Professional Services			47	47		47	125,383	125,430			19
20	Dues, Fees, Subscriptions & Promotions					20,530	20,530		20,530			20
21	Clerical & General Office Expenses	410,941	309,776	131,348	852,065		852,065		852,065			21
22	Employee Benefits & Payroll Taxes			4,940,995	4,940,995		4,940,995	443,181	5,384,176			22
23	Inservice Training & Education											23
24	Travel and Seminar			33,337	33,337		33,337		33,337			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							264,287	264,287			26
27	Other (specify):*											27
28	TOTAL General Administration	1,030,837	369,858	5,209,044	6,609,739		6,609,739	2,313,949	8,923,688			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	17,589,288	2,337,583	8,137,331	28,064,202	(200,921)	27,863,281	2,641,131	30,504,412			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: 12/01/2015 Ending: 11/30/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,051,469	1,051,469		1,051,469		1,051,469			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			187,729	187,729		187,729	962	188,691			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,239,198	1,239,198		1,239,198	962	1,240,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	441,255	2,395,520	93,004	2,929,779	200,921	3,130,700	(31,381)	3,099,319			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							875,480	875,480			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	441,255	2,395,520	93,004	2,929,779	200,921	3,130,700	844,099	3,974,799			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	18,030,543	4,733,103	9,469,533	32,233,179		32,233,179	3,486,192	35,719,371			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: 12/01/2015 Ending: 11/30/2016

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				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	(7,051)	39		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	3,493,243			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 3,486,192		$	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			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 3,486,192		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	Part B Therapy	X		200,921	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 200,921		47

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: 12/01/2015

Ending: 11/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing - Administration	$ (1,774)	17	1
2	Cafeteria Income	(773,362)	2	2
3	Campus cleaning Svc income	(194,444)	3	3
4	Misc revenue	(27,149)	17	4
5	refunds and overpayments	(40,854)	17	5
6				6
7	Wellness Center Income	(24,330)	39	7
8	Provider Participation Fees Exp	875,480	42	8
9	Service Fee Income	(24,303)	17	9
10				10
11				11
12	DuPage County Cost Alloc.- heating and Other Utilities	1,189,904	5	12
13	DuPage County Cost Alloc.-Equip repair/maint.	105,084	6	13
14	DuPage County Cost Alloc.- administration	1,575,178	17	14
15	DuPage County Cost Alloc.- employee benefits	443,181	22	15
16	DuPage County Cost Alloc.- Prof. liability ins.	264,287	26	16
17	DuPage County Cost Alloc.- Equipment lease	962	35	17
18	DuPage County Cost Alloc. - Professional	125,383	19	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**	3,493,243		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center **#** 0008201 **Report Period Beginning:** 12/01/2015 **Ending:** 11/30/2016

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	(773,362)	0	0	0	0	0	0	0	0	0	0	(773,362)	2
3	Housekeeping	(194,444)	0	0	0	0	0	0	0	0	0	0	(194,444)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	1,189,904	0	0	0	0	0	0	0	0	0	0	1,189,904	5
6	Maintenance	105,084	0	0	0	0	0	0	0	0	0	0	105,084	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	327,182	0	0	0	0	0	0	0	0	0	0	327,182	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	1,481,098	0	0	0	0	0	0	0	0	0	0	1,481,098	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	125,383	0	0	0	0	0	0	0	0	0	0	125,383	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	443,181	0	0	0	0	0	0	0	0	0	0	443,181	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	264,287	0	0	0	0	0	0	0	0	0	0	264,287	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	2,313,949	0	0	0	0	0	0	0	0	0	0	2,313,949	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	2,641,131	0	0	0	0	0	0	0	0	0	0	2,641,131	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Du Page Convalescent Center **#** 0008201 **Report Period Beginning:** 12/01/2015 **Ending:** 11/30/2016

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	962	0	0	0	0	0	0	0	0	0	0	962	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	962	0	0	0	0	0	0	0	0	0	0	962	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	(31,381)	0	0	0	0	0	0	0	0	0	0	(31,381)	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	875,480	0	0	0	0	0	0	0	0	0	0	875,480	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	844,099	0	0	0	0	0	0	0	0	0	0	844,099	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,486,192	0	0	0	0	0	0	0	0	0	0	3,486,192	45

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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 ☐ 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: 12/01/2015 Ending: 11/30/2016

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Fichtner, Paul	BOD						1
2	Puchalski, Donald E	BOD						2
3	Tornatore, Sam	BOD						3
4	Chaplin, Elizabeth	BOD						4
5	DiCianni, Peter	BOD						5
6	Noonan, Sean	BOD						6
7	Curran, John F	BOD						7
8	Grasso, Gary	BOD						8
9	Krajewski, Brian J.	BOD						9
10	Eckhoff, Grant	BOD						10
11	Elliott, Tim	BOD						11
12	Grant, Amy	BOD						12
13	Anderson, Janice	BOD						13
14	Healy, James D.	BOD						14
15	Khouri, Tonia	BOD						15
16	Larsen, Robert L	BOD						16
17	Wiley, Kevin	BOD						17
18	Zay, James F., Jr.	BOD						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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 1/30/2016

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		Please refer to Page 8-1 for the details				$	$		$	1
2										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

FY2016 Indirect Cost Summary by Department

Indirect Cost Accruals

1200-2020 Convalescent Center Operating Fund

	Expenditure Object	FY 2016 TOTAL
Paid To:		
1100-1210 I.M.R.F.	$ 51,010.00	$ -
1100-1211 Social Security	51030	-
1000-1150 Operating Supls/Materials	52200	-
1000-1150 Finance A/P	53000	50,313.76
1000-4000 County Auditor	53000	15,063.41
1000-1150 Finance-Gen Acct/Budgeting	53000	26,374.06
1000-1170 Audit	53000	12,470.87
1000-1110 IT Svc	53020	754,363.08
1000-1110 Printing	53800	-
1000-1110 Wired Communication Svcs	53250	10,847.13
1000-1150 Finance-Mailroom	53804	6,457.94
1100-1212 Liability Insurance	53090	-
1100-1212 Liability Insurance	53100	-
1100-1212 Liability Insurance	53110	423,294.70
1000-1200 Corporate Fund Ins	53120	28,944.55
1100-1212 Liability Insurance	53130	235,341.97
1100-1212 Liability Insurance	53140	8,678.28
1100-1212 Liability Insurance	53160	19,885.65
1100-1212 Liability Insurance	53170	22,592.74
1100-1212 Liability Insurance	53610	344.45
1000-1100 Facilities Mgmt - Pwr Plant	53300	1,189,830.58
1000-1150 Finance - Pager Rental	53410	961.87
1000-1100 Facilities Mgmt - Bldg Mtce	53300	-
1000-1180 Spec Accts	53090	17,783.12
1000-1180 Spec Accts	53410	-
1000-1180 Spec Accts	53370	4,995.00
1000-1180 Spec Accts	53808	10.00
1000-1180 Spec Accts	53830	3,627.54
1000-1180 Spec Accts	53803	-
1000-1120 Personnel	53830	333,251.26
1000-1100 Facilities Mgmt - Utilities	53230	73.28
1000-1100 Facilities Mgmt-Space	53300	-
1000-1150 Finance-Purchasing	53090	107,599.90
1000-1130 Personnel-Security	53809	312,266.94
1500-3530 Roads & Grounds	53812	100,088.84
1000-1001 County Board	53815	18,517.05
GRAND TOTAL		$ 3,703,977.97

**Include Convo costs even though I don't bill them

Postage already paid

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Du Page Convalescent Center **#** 0008201 **Report Period Beginning:** 12/01/2015 **Ending:** 11/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 Deb Freeland

TELEPHONE 317-569-6230 FAX #: 317-574-9707

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 12/01/2015 Ending: 11/30/2016

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).

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:
(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: 12/01/2015 Ending: 11/30/2016

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		1,163,231	7
8	100			1993	6,532,578	6,767		6,767		5,229,149	8
	Improvement Type**										
9	Fiscal Year 1976			1976	2,669,916	200,202	20	200,202		81,461	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	1,597,478		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	227	19	227		331,427	18
19	Remodel, HVAC and Electrical			1992	604,208	144	18	144		604,128	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	18,635	16	18,635		305,497	24
25	UNTAGABLE AUTOMATIC DOOR NORTH and Garage + Elevator Instal.			1998	10,922	202	13	202		10,689	25
26	Roof, Remodel and HVAC Work			1999	701,043	4,526	12	4,526		690,537	26
27	Roof, Remodel, Plumbing, and HVAC Work			2000	832,461	11,066	12	11,066		832,461	27
28	Remodel, plubming and electrical work			2001	473,208		10			473,208	28
29	Roof, Remodel and HVAC Work			2002	1,911,073	14,277	10	14,277		1,814,208	29
30	Alarm system, carpet and curtain wall instal.			2003	376,034	2,460	12	2,460		364,037	30
31	Carpet, alarm replacement, andr remodel.			2004	182,683		8			182,683	31
32	Remodel and HVAC			2005	182,276	7,812	7	7,812		182,276	32
33	Remodel and HVAC			2006	2,653,570	246,210	8	246,210		1,668,190	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: 12/01/2015 Ending: 11/30/2016

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	$ 1,362	10	$ 1,362	$	$ 6,289	37
38	BUILDING PERMIT FOR OFFICE REL	2009	5,230	365	20	365		1,892	38
39	ROOF REPLACEMENT	2009	13,500	1,260	15	1,260		5,767	39
40	WEST CORRIDOR EXTENSION PROJEC	2009	79,193	11,160	10	11,160		50,876	40
41	RESIDENT DINING ROOM ROOF REPL	2009	107,567	10,043	15	10,043		45,957	41
42	WINDOW REPLACEMENT	2009	115,487	16,275	10	16,275		74,192	42
43	NEW LOBBY ENTRANCE	2009	18,992	2,677	10	2,677		12,202	43
44	CARPET/FLOOR TILE REMOVAL	2009	2,605	367	10	367		1,673	44
45	KITCHEN ROOF TOP AIRHANDLER	2009	10,908	1,538	10	1,538		7,100	45
46	NURSE CALL SYSTEM	2009	180,441	25,429	10	25,429		115,921	46
47	FIRE PROTECTION - LIFE SAFETY	2009	79,152	11,155	10	11,155		50,850	47
48	FLOORING REPLACEMENT, 3-CENTER	2009	18,900	-	5	-		18,900	48
49									49
50	SOUTH BUILDING RENOVATION	2010	1,100,966	76,903	20	76,903		811,133	50
51	EASTWING GROUND FLOOR RENOVATI	2010	92,414	6,454	20	6,454		25,732	51
52	1 NORTH DAY ROOM REMODELING	2010	8,382	1,179	10	1,179		4,613	52
53	ELEVATOR CARD READER INSTALLAT	2010	1,844	540	5	540		2,190	53
54	HENRY HYDE - MARQUEE SIGN	2010	29,225	4,111	10	4,111		16,083	54
55	LIGHTING STUDY	2010	4,900	346	5	346		4,900	55
56	BUILDING NEEDS ASSESSENT	2010	20,121	3,500	5	3,500		20,121	56
57	BUILDING PERMIT, EAST HALLWAY	2010	875	107	5	107		875	57
58	TRANSFER OF NURSE CALL SYSTEM	2010	3,996	563	10	563		2,467	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)**		**$ 30,052,595**	**$ 690,808**		**$ 690,808**	**$**	**$ 26,944,002**	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: 12/01/2015 Ending: 11/30/2016

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		$ 30,052,595	$ 690,808		$ 690,808	$	$ 26,944,002	1
2	ROOF EXHAUST SUPPLIES - EAST W	2011	5,004	703	10	703		2,252	2
3	WELLNESS CENTER	2011	161,412	22,672	10	22,672		72,625	3
4	REPLACEMENT FLOORING	2011	10,700	3,060	5	3,060		9,725	4
5	REPLACEMENT OF FLOORING	2011	12,808	3,662	5	3,662		11,640	5
6	CARPETING	2011	4,134	1,186	5	1,186		4,040	6
7	SHOWER ROOM FLOORS	2011	13,137	1,845	10	1,845		5,910	7
8	PLUMBING FOR VOLUNTEER OFFICE	2011	6,215	873	10	873		2,952	8
9	RENOVATION OF 4 SHOWER FLOORS	2011	62,904	8,840	10	8,840		30,407	9
10	HOT WATER HEATER	2011	13,639	3,918	5	3,918		13,564	10
11	LAVATORY SINK IN BATHROOM	2011	747	105	10	105		373	11
12	WIFI INSTALLATION	2011	4,007	1,154	5	1,154		4,123	12
13	BIG BEAM LED EXIT SIGNS	2011	15,069	2,117	10	2,117		6,781	13
14	DRIVEWAY REPLACEMENT	2011	20,512	5,865	5	5,865		18,641	14
15	DOORS/DOOR CLOSURES REPLCEMNTS	2011	11,435	1,606	10	1,606		5,145	15
16	SUPPLY & INSTALL FIRE RATED CE	2011	3,512	493	10	493		1,580	16
17	FIRE SAFETY MATERIAL & INSTALL	2011	3,409	479	10	479		1,534	17
18	DOOR & FRAME FOR TUB ROOM	2011	612	86	10	86		301	18
19	SMOKE DECTECTORS & EQUIPMENT I	2011	15,916	2,237	10	2,237		7,960	19
20	MEDICAL VACUUM	2011	27,983	3,934	10	3,934		14,462	20
21	UPGRADE OF FIRE SYSTEM	2011	11,539	1,622	10	1,622		5,964	21
22									22
23	ROOF REPAIR & ROOF WALK INSTAL	2012	51,079	7,166	10	7,166		17,859	23
24	WINDOW REPLACEMENT	2012	20,549	2,883	10	2,883		7,185	24
25	VARIOUS FLOORING PROJECTS	2012	28,994	8,232	5	8,232		20,446	25
26	WELLNESS CENTER FLOORING	2012	14,698	4,173	5	4,173		10,365	26
27	DAYROOM SURVEY DOCUMENTS	2012	19,945	2,799	10	2,799		7,141	27
28	WINDOW REPLACMENT	2012	5,915	1,689	5	1,689		5,174	28
29	RESIDENT DINING ROOM FLOORING	2012	52,255	14,836	5	14,836		36,850	29
30	BARCO JOINTS	2012	6,568	921	10	921		2,296	30
31	CABLE INSTALLATION FOR WIRELES	2012	75,762	21,510	5	21,510		53,427	31
32	MAT./INSTALL LAUNDRY BARCO JOI	2012	8,027	1,126	10	1,126		2,873	32
33	FURNISH/INST PIPES, HOT WATER	2012	30,063	8,547	5	8,547		22,724	33
34	**TOTAL (lines 1 thru 33)**		**$ 30,771,143**	**$ 831,147**		**$ 831,147**	**$**	**$ 27,350,321**	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: 12/01/2015 Ending: 11/30/2016

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		$ 30,771,143	$ 831,147		$ 831,147	$	$ 27,350,321	1
2	CABLING FOR RESIDENTS TV'S	2012	65,956	-	5	-		65,956	2
3	FLOORING INSTALLATION - NORTH	2012	10,919	3,111	5	3,111		8,994	3
4									4
5	TIMBER ROOF TERRACE REPLACE	2013	68,616	9,618	10	9,618		17,114	5
6	WELLNESS CENTER SECURITY ADD	2013	4,400	617	10	617		1,098	6
7	WELLNESS CENTER RENOVATION	2013	68,211	9,561	10	9,561		17,013	7
8	REPLACEMENT FLOORING	2013	26,686	3,741	10	3,741		6,656	8
9	NURSE CALL SYSTEM	2013	79,067	22,353	5	22,353		39,775	9
10	SMOKER'S SHELTER	2013	3,835	1,087	5	1,087		7,769	10
11	FURNISH & INSTALL HANDRAILS	2013	16,600	2,328	10	2,328		6,715	11
12	FURNISH/INSTALL HANDRAILS STAI	2013	10,000	2,837	5	2,837		6,715	12
13				-		-			13
14	Induction Air Terminal Replace	2014	4,840	673	10	673		794	14
15	Nurse Call Sys-Rayland Respond	2014	76,082	10,575	10	10,575		15,013	15
16	Replace Flring Various Locatio	2014	39,241	5,454	10	5,454		8,724	16
17									17
18	Kitchen Redesign/Renovation	2015	5,525,186	18,753	5	18,753		18,753	18
19	Porte Cochere	2015	355,282	15,921	5	15,921		15,921	19
20	Roof Replacement	2015	11,464	191	5	191		191	20
21	Resident Room Rehab	2015	598,725	9,979	5	9,979		9,979	21
22	Roof Coping Metal Protection - Leaks & Lightening	2015	3,580	209	10	209		209	22
23	Fabricate & Install Metal Slope on Roof	2015	9,800	29	20	29		29	23
24	Oxygen Isolation Valves & Cabinets	2015	37,492	109	20	109		109	24
25	Emergency O2 Backup Bank - 1East	2015	4,000	12	20	12		12	25
26	Bathroom Floor Upgrades on Resident Units	2015	26,595	78	20	78		78	26
27	Active Assist Exercise Bike	2015	5,367	157	5	157		157	27
28									28
29	Elevator Emergency Lighting and Alarm	2016	3,287	219	5	219		219	29
30	Lighting for Outdoor Education Area	2016	1,810	60	5	60		60	30
31	Roof Repair	2016	27,654	461	10	461		461	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 37,855,838	$ 949,280		$ 949,280	$	$ 27,598,835	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: 12/01/2015 Ending: 11/30/2016

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	$ 2,348,675	$ 84,554	$ 84,554	$	10	$ 2,267,398	71
72	Current Year Purchases	234,671	11,733	11,733		5	11,733	72
73	Fully Depreciated Assets	2,729,623				11	2,729,623	73
74								74
75	TOTALS	$ 5,312,969	$ 96,287	$ 96,287	$		$ 5,008,754	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	2,824	2,824		8	32,280	77
78	Maint and Transport	Ford F250 2010	2010	77,015	2,541	2,541		8	77,015	78
79	Maint and Transport	Extended Length Van 2011	2011	31,300	537	537		8	31,300	79
80	TOTALS			$ 252,621	$ 5,902	$ 5,902	$		$ 252,621	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)	$ 44,215,788	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,051,469	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,051,469	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)	$ 32,860,210	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	$ 28,104	92
93			93
94			94
95		$ 28,104	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: 12/01/2015 Ending: 11/30/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 188,692 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	$	$	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.

Account Number	Vendor	Rental	Amount		
2000-53410	Toshiba America Bus S	Copier Rental	$ 50,344.08	$	50,344.08
2020-53410	DuPage County	Pager Rentals	$ 961.87	$	961.87
2025-53410	Ecolab Inc.	Dish Machine Conveyor	$ 4,625.40	$	4,625.40
2035-53410	Medco Equipment Inc.	Wheelchair Washer Rental	$ 2,340.00	$	2,340.00
2050-53410	Ezway	Respiratory Equipment/CPAP/Bi-P	$ 33.90		
2050-53410	Advacare Systems	Air Matress', Air Therapy Beds, CPM Machine, Leg & Foot	$ 68,273.32		
2050-53410	Pulmonary Exchange	Respiratory Equipment	$ 10,080.00		
2050-53410	Hill-ROM	Bed Rentals	$ 25,470.00		
2050-53410	Intragrated Healthcare Equipment	Low Air Mattress	$ 114.00		
2050-53410	Medical Specialties	Pump Rentals	$ 3,838.56		
2050-53410	Fitzsimmons Hospital Services	Smart Vest Rental	$ 959.00	$	108,768.78
2055-53410	Advacare Systems	Air Matress', Air Therapy Beds, CPM Machine, Leg & Foot	$ 5,116.00		
	Fitzsimmons Hospital Services	Smart Vest Rental	$ 1,367.43		
	Hill-ROM	Bed Rentals	$ 1,710.00		
2055-53410	Pulmonary Exchange	Respiratory Equipment	$ 970.00		
2055-53410	Medical Specialties	Pump Rentals	$ 1,923.04	$	11,086.47
2075-53410	Airgas USA LLC	Oxygen Rental	$ 10,565.40	$	10,565.40
2100-53410	American Compressed Gases Inc	Cafeteria Soda Carbanation	$ -	$	-
			$ 188,692.00		

2000-53410	$ 50,344.08
2020-53410	$ 961.87
2025-53410	$ 4,625.40
2035-53410	$ 2,340.00
2050-53410	$ 108,768.78
2055-53410	$ 11,086.47
2075-53410	$ 10,565.40
2100-53410	$ -
	$ 188,692.00

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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: 12/01/2015 Ending: 11/30/2016

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			hrs							4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39-8	61274	# of prescrpts	1,759,036				61,274	1,759,036	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				$ 1,759,036		$	$	61,274	$ 1,759,036	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.

Payor	Pharmacy Charges	Medication Costs
Medicaid	$87,316.86	$83,995.32
Medicare Part D	$1,903,836.51	$1,400,384.46
Private	$182,909.62	$73,718.90
Medicare	$484,663.29	$136,842.57
Insurance	$188,292.48	$53,498.59
Hospice	$15,171.73	$10,595.70
Totals	$2,862,190.49	$1,759,035.54

# of prescriptions	Inpatient	57,969
	Outpatient	3,305
		61,274

Prepared by:

Dale Wagener
Pharmacy Manager

STATE OF ILLINOIS

Facility Name & ID Number Du Page Convalescent Center **#** 0008201 **Report Period Beginning:** 12/01/2015 **Ending:** 11/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/2016 **(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	$ 1,609,494	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,591,738)	11,229,489		3
4	Supply Inventory (priced at)	299,960		4
5	Short-Term Investments	8,250		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	9,178		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 13,156,371	$	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	37,883,942		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,565,590		16
17	Accumulated Depreciation (book methods)	(32,860,210)		17
18	Deferred Charges	(668,853)		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):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,704,829	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 23,861,200	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 627,349	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,912,188		30
31	Accrued Taxes Payable (excluding real estate taxes)	223,786		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	435,877		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,199,200	$	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	Noncurrent benefits	136,962		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 136,962	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,336,162	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 19,525,038	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 23,861,200	$	48

***(See instructions.)**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,089,967	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,089,967	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,451,702)	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) **Transfer in General fund**	3,000,000	15
16	Other (describe) **contributed capital**	8,886,773	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 9,435,071	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 19,525,038	24 *

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

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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	$ 29,587,850	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 29,587,850	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		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	773,362	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,663,792	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,349	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,438,503	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,561	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,561	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Please refer to PG19A for details	439,542	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 439,542	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 33,485,456	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	5,565,592	31
32	Health Care	15,888,871	32
33	General Administration	6,609,739	33
	B. Capital Expense		
34	Ownership	1,239,198	34
	C. Ancillary Expense		
35	Special Cost Centers	2,929,779	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Indirect expenses	3,703,979	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 35,937,158	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,451,702)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,451,702)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 17,855,205	44
45	Private Pay - Net Inpatient Revenue	7,978,396	45
46	Medicare - Net Inpatient Revenue	3,754,249	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 29,587,850	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 Convalescent Center
Medicaid Provider Number: 0008201
Medicare Provider Number: 14-5050
FYE: 11/30/2015
WS A-8 : Non Operrating Revenue

Acct	Description	Category Non Op Rev	Reported separetly on Page 19 or Page 18	Other Non Oper Revenue	
42000	service fee	(24,303)		(24,303)	
42080	wellness center fee	(24,330)		(24,330)	
42081	convo cafeteria earnings	(300,641)	(300,641)	-	
42082	jtk cafeteria earnings	(74,386)	(74,386)	-	
42083	jof cafeteria earnings	(245,105)	(245,105)	-	
42085	catering service earnings	(153,230)	(153,230)	-	
42086	vending machine earnings	(21,275)		(21,275)	
42087	campus cleaning service fee	(194,444)		(194,444)	
42088	laundry service reimb fee	(1,349)	(1,349)	-	
45000	investment income	(19,561)	(19,561)	-	
46000	Contrubuted Capital	-	-	-	Reported on PG 18
46000	miscellaneous revenue	(5,874)		(5,874)	
46006	refunds and overpayments	(40,854)		(40,854)	
46030	Other Reimb	(128,462)		(128,462)	
47000	transfer in general fund	(3,000,000)	(3,000,000)	-	Reported on PG 18
Grand Total		(4,233,814)	(3,794,272)	(439,542)	
	To Be Transferred to line 28A - Page 19			(439,542)	

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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	1,703	1,980	$ 133,937	$ 67.64	1
2	Assistant Director of Nursing	2,758	3,205	128,751	40.17	2
3	Registered Nurses	85,610	160,362	3,861,318	24.08	3
4	Licensed Practical Nurses	31,055	58,279	951,830	16.33	4
5	CNAs & Orderlies	270,790	479,798	5,048,919	10.52	5
6	CNA Trainees					6
7	Licensed Therapist	1,662	1,981	75,053	37.89	7
8	Rehab/Therapy Aides	23,666	27,904	520,990	18.67	8
9	Activity Director	1,450	1,968	50,680	25.75	9
10	Activity Assistants	20,009	23,048	431,956	18.74	10
11	Social Service Workers	10,758	12,498	290,239	23.22	11
12	Dietician	5,464	6,183	136,644	22.10	12
13	Food Service Supervisor	1,701	1,980	49,612	25.06	13
14	Head Cook	9,879	13,124	195,123	14.87	14
15	Cook Helpers/Assistants	71,339	77,186	1,034,150	13.40	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	78,367	90,330	1,128,974	12.50	18
19	Laundry	24,961	27,771	330,970	11.92	19
20	Administrator	1,669	2,020	145,910	72.23	20
21	Assistant Administrator	3,396	4,075	206,735	50.73	21
22	Other Administrative	9,297	10,875	267,251	24.57	22
23	Office Manager					23
24	Clerical	15,492	18,097	410,941	22.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	10,241	11,747	237,682	20.23	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,039	3,545	77,756	21.93	31
32	Other Health Care(specify)	109,577	158,013	2,315,122	14.65	32
33	Other(specify) Ancillary Services					33
34	TOTAL (lines 1 - 33)	793,883	1,195,969	$ 18,030,543 *	$ 15.08	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				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)		$		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	6,322	267,047	10-3	51
52	Certified Nurse Assistants/Aides	30,375	764,482	10-3	52
53	TOTAL (lines 50 - 52)	36,697	$ 1,031,529		53

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Ulmer	Administrator	None	$ 145,910
Support Staff	Support Staff	None	473,986
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 619,896

B. Administrative - Other

Description	Amount
See Trial Balance detail	$ 103,317
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 103,317

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	$ 423,295
Unemployment Compensation Insurance	19,886
FICA Taxes	1,350,692
Employee Health Insurance	1,431,433
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	2,153,660
Tuition reimbursement	5,210
TOTAL (agree to Schedule V, line 22, col.8)	$ 5,384,176

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
LeadingAge Illinois	20,530
Polaris Group	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,530

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	798
Seminar Expense	32,539
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 33,337

* Attach copy of IMRF notifications

**See instructions.

Final Notice of Illinois Municipal Retirement Fund Contribution Rate for Calendar Year 2016

Date November 2015

Employer name DUPAGE COUNTY Employer No. 02999

The contribution rates on earnings paid by your participating governmental unit to IMRF members are shown below. The Illinois Pension Code provides that the employer is responsible for remitting both employer and member contributions to IMRF along with the related deposit report according to prescribed due dates.

IMRF contributions must be paid on the earnings of all employees working in participating positions. Your employer contribution rate on member earnings is based upon actuarial costs for retirement, supplemental retirement, death, and disability benefits. The actuarial formula is specified in the Illinois Pension Code. Member contributions are specified in the Illinois Pension Code and help to meet the cost of future retirement benefits.

Participating governmental units with taxing powers are authorized by the Illinois Pension Code to levy a special IMRF tax for payment of employer IMRF contributions. However, this levy may be used only for employer payments. It may not be used for payment of IMRF member contributions. These must be paid out of the same fund from which the employee IMRF earnings are paid. Interest charges are assessed on any late payments. Refer to Section 4 of the IMRF Manual for Authorized Agents for interest charge procedures. If you have any questions, please contact the IMRF Employer Account Analyst at 1-800-ASK-IMRF.

Louis W. Kosiba, Executive Director

	IMRF Contributions Regular	SLEP	ECO
Member Contributions (tax-deferred)	4.50%	7.50%	7.50%
Employer Contributions			
• **Retirement Rate**			
Normal Cost	6.03%	12.05%	16.50%
Funding Adjustment <over> under	5.40%	11.63%	72.02%
Net Retirement Rate	11.43%	23.68%	88.52%
• **Other Program Benefits**			
Death	0.13%	0.14%	0.15%
Disability	0.14%	0.14%	0.14%
Supplemental Benefit Payment	0.62%	0.62%	0.62%
Early Retirement Incentive	0.00%	0.00%	0.00%
SLEP Enhancement	0.00%	1.27%	0.00%
• **TOTAL EMPLOYER RATE**	[illegible]	[illegible]	[illegible]

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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. **LeadingAge Illinois $20530**

(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. $ **244,718** 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. $ **875,480**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **773,362**

(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: **N/A**

(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