FOR BHF USE

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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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0008201

Facility Name: Du Page Care 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: 1/01/1935

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 12/01/2016 to 11/30/2017 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) Janelle Chadwick
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Deborah Freeland, Principal
(Firm Name & Address) CliftonLarsonAllen LLP, 9365 Counselors Row, Ste 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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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	134,320	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	88,653	21,539	8,001	118,193	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	88,653	21,539	8,001	118,193	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.99%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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, Employee 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 1/01/1938

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 6,668

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: 11/30/2017 Fiscal Year: 11/30/2017

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

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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	1,748,615	118,445	5,111	1,872,171		1,872,171		1,872,171			1
2	Food Purchase		1,195,027		1,195,027		1,195,027	(771,390)	423,637			2
3	Housekeeping	1,135,059	129,564	49,718	1,314,341		1,314,341	(161,542)	1,152,799			3
4	Laundry	357,087	131,231	5,039	493,357		493,357		493,357			4
5	Heat and Other Utilities			595,738	595,738		595,738	1,480,381	2,076,119			5
6	Maintenance		2,480	50,210	52,690		52,690	121,647	174,337			6
7	Other (specify):*											7
8	TOTAL General Services	3,240,761	1,576,747	705,816	5,523,324		5,523,324	669,096	6,192,420			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	14,853,563	103,261	680,250	15,637,074		15,637,074		15,637,074			10
10a	Therapy	605,604	22,732	1,065,970	1,694,306	(488,273)	1,206,033		1,206,033			10a
11	Activities	492,814	3,932	287	497,033		497,033		497,033			11
12	Social Services	578,184	6,350	4,678	589,212		589,212		589,212			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	16,530,165	136,275	1,751,185	18,417,625	(488,273)	17,929,352		17,929,352			16
	C. General Administration											
17	Administrative	671,161	96,606	181,180	948,947		948,947	1,775,583	2,724,530			17
18	Directors Fees											18
19	Professional Services			7,000	7,000		7,000	116,035	123,035			19
20	Dues, Fees, Subscriptions & Promotions			33,330	33,330		33,330	(3,266)	30,064			20
21	Clerical & General Office Expenses	378,929	10,805	331,829	721,563		721,563	(317,048)	404,515			21
22	Employee Benefits & Payroll Taxes			6,931,002	6,931,002		6,931,002	497,513	7,428,515			22
23	Inservice Training & Education											23
24	Travel and Seminar			24,349	24,349		24,349		24,349			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							353,397	353,397			26
27	Other (specify):*											27
28	TOTAL General Administration	1,050,090	107,411	7,508,690	8,666,191		8,666,191	2,422,214	11,088,405			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	20,821,016	1,820,433	9,965,691	32,607,140	(488,273)	32,118,867	3,091,310	35,210,177			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 Care Center #0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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			882,025	882,025		882,025	(1,162)	880,863			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			163,432	163,432	(87,115)	76,317	726	77,043			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,045,457	1,045,457	(87,115)	958,342	(436)	957,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	433,662	2,973,192	105,577	3,512,431	575,388	4,087,819	(33,052)	4,054,767			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							878,989	878,989			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	433,662	2,973,192	105,577	3,512,431	575,388	4,087,819	845,937	4,933,756			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	21,254,678	4,793,625	11,116,725	37,165,028		37,165,028	3,936,811	41,101,839			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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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	(326,732)	21		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	(6,961)	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 See PG5A	4,270,504			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 3,936,811		$	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))**	$ 3,936,811		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		575,388	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 575,388		47

Du Page Care Center

ID# 0008201

Report Period Beginning: 12/01/2016

Ending: 11/30/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing - Administration	$ (1,634)	17	1
2	Cafeteria Income	(771,390)	2	2
3	Campus Cleaning Svc Income	(161,542)	3	3
4	Misc Revenue	(31,446)	17	4
5	Refunds & Overpayments	(29,728)	17	5
6	Wellness Center Income	(26,091)	39	6
7	Provider Participation Fees Exp	878,989	42	7
8	Service Fee Income	(9,755)	17	8
9				9
10	DuPage County Cost Alloc - Heating/Utilities	1,480,381	5	10
11	DuPage County Cost Alloc - Equip Repair/Maint	121,647	6	11
12	DuPage County Cost Alloc - Administration	1,848,146	17	12
13	DuPage County Cost Alloc - Employee Benefits	497,513	22	13
14	DuPage County Cost Alloc - Prof. Liability Ins.	353,397	26	14
15	DuPage County Cost Alloc - Equipment Lease	726	35	15
16	DuPage County Cost Alloc - Professional	116,035	19	16
17	DuPage County Cost Alloc - Clerical (Postage paid)	9,684	21	17
18				18
19	Straigt line depreciation adjustment	(1,162)	30	19
20	Non-allowable adversting	(3,266)	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**	4,270,504		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Care Center **#** 0008201 **Report Period Beginning:** 12/01/2016 **Ending:** 11/30/2017

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	(771,390)	0	0	0	0	0	0	0	0	0	0	(771,390)	2
3	Housekeeping	(161,542)	0	0	0	0	0	0	0	0	0	0	(161,542)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	1,480,381	0	0	0	0	0	0	0	0	0	0	1,480,381	5
6	Maintenance	121,647	0	0	0	0	0	0	0	0	0	0	121,647	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	669,096	0	0	0	0	0	0	0	0	0	0	669,096	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	1,775,583	0	0	0	0	0	0	0	0	0	0	1,775,583	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	116,035	0	0	0	0	0	0	0	0	0	0	116,035	19
20	Fees, Subscriptions & Promotions	(3,266)	0	0	0	0	0	0	0	0	0	0	(3,266)	20
21	Clerical & General Office Expenses	(317,048)	0	0	0	0	0	0	0	0	0	0	(317,048)	21
22	Employee Benefits & Payroll Taxes	497,513	0	0	0	0	0	0	0	0	0	0	497,513	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	353,397	0	0	0	0	0	0	0	0	0	0	353,397	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	2,422,214	0	0	0	0	0	0	0	0	0	0	2,422,214	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	3,091,310	0	0	0	0	0	0	0	0	0	0	3,091,310	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Du Page Care Center **#** 0008201 **Report Period Beginning:** 12/01/2016 **Ending:** 11/30/2017

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	(1,162)	0	0	0	0	0	0	0	0	0	0	(1,162)	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	726	0	0	0	0	0	0	0	0	0	0	726	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(436)	0	0	0	0	0	0	0	0	0	0	(436)	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	(33,052)	0	0	0	0	0	0	0	0	0	0	(33,052)	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	878,989	0	0	0	0	0	0	0	0	0	0	878,989	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	845,937	0	0	0	0	0	0	0	0	0	0	845,937	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,936,811	0	0	0	0	0	0	0	0	0	0	3,936,811	45

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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, Donaled 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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 1/30/2017

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		See PG8-1				$	$		$	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

DuPage Convalescent Center
Medicaid Provider Number: 0008201
Medicare Provider Number: 14-5050
FYE: 11/30/2017
Indirect Cost Accruals: 1200-2020 Convalescent Center Operating Fund

Expenditure Object	Description	FY2017 Total
51010	1100-1210 I.M.R.F.	-
51030	1100-1211 Social Security	-
52200	1000-1150 Operating Supls/Materials	-
53000	1000-1150 Finance A/P	78,057
53000	1000-4000 County Auditor	20,413
53000	1000-1150 Finance-Gen Acct/Budgeting	26,788
53000	1000-1170 Audit	13,339
53020	1000-1110 IT Svc	1,015,047
53800	1000-1110 Printing	-
53250	1000-1110 Wired Communication Svcs	9,292
53804	1000-1150 Finance-Mailroom	8,137
53090	1100-1212 Liability Insurance	10,204
53100	1100-1212 Liability Insurance	-
53110	1100-1212 Liability Insurance	479,420
53120	1000-1200 Corporate Fund Ins	25,108
53130	1100-1212 Liability Insurance	328,289
53140	1100-1212 Liability Insurance	5,000
53160	1100-1212 Liability Insurance	18,093
53170	1100-1212 Liability Insurance	17,594
53610	1100-1212 Liability Insurance	66
53300	1000-1100 Facilities Mgmt - Pwr Plant	1,480,381
53410	1000-1150 Finance - Pager Rental	726
53300	1000-1100 Facilities Mgmt - Bldg Mtce	-
53090	1000-1180 Spec Accts	-
53410	1000-1180 Spec Accts	-
53370	1000-1180 Spec Accts	2,919
53808	1000-1180 Spec Accts	-
53830	1000-1180 Spec Accts	2,756
53803	1000-1180 Spec Accts	-
53830	1000-1120 Personnel	303,546
53230	1000-1100 Facilities Mgmt - Utilities	-
53300	1000-1100 Facilities Mgmt-Space	-
53090	1000-1150 Finance-Purchasing	105,831
53809	1000-1130 Personnel-Security	328,490
53812	1500-3530 Roads & Grounds	118,728
53815	1000-1001 County Board	19,621
Grand Total		4,417,846

$ 9,683.76 Postage paid

$ 4,427,529.60

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Du Page Care Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0008201

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 258,737 B. General Construction Type: Exterior Masonry Rough Concr 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: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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	1978	$ 4,456,549	$	30	$	$	$ 4,456,549	4
5	148		1947	1947	70,858		5			70,858	5
6	16		1979	1979	1,750,523		30			1,750,523	6
7			1964	1983	1,172,064		34			1,172,064	7
8	100		1993	1993	6,516,821	92,979	VARIOUS	92,979		5,303,583	8
	Improvement Type**										
9	1976 IMPROVEMENTS			1976	44,372		VARIOUS			44,372	9
10	1977 IMPROVEMENTS			1977	8,545		VARIOUS			8,545	10
11	1978 IMPROVEMENTS			1978	12,188		VARIOUS			12,188	11
12	1979 IMPROVEMENTS			1979	844		VARIOUS			844	12
13	1981 IMPROVEMENTS			1981	212,304		VARIOUS			212,304	13
14	1983 IMPROVEMENTS			1983	1,597,478		VARIOUS			4,134,469	14
15	1985 IMPROVEMENTS			1985	91,792		VARIOUS			91,792	15
16	1990 IMPROVEMENTS			1990	199,883		VARIOUS			199,883	16
17	1991 IMPROVEMENTS			1991	5,423		VARIOUS			5,423	17
18	1992 IMPROVEMENTS			1992	604,207		VARIOUS			935,720	18
19	1993 IMPROVEMENTS			1993	588,826		VARIOUS			642,712	19
20	1994 IMPROVEMENTS			1994	105,577		VARIOUS			105,577	20
21	1995 IMPROVEMENTS			1995	31,457		VARIOUS			31,457	21
22	1996 IMPROVEMENTS			1996	7,963		VARIOUS			7,963	22
23	1997 IMPROVEMENTS			1997	320,587		VARIOUS			320,587	23
24	1998 IMPROVEMENTS			1998	10,922	145	VARIOUS	145		10,922	24
25	1999 IMPROVEMENTS			1999	701,043	3,256	VARIOUS	3,256		695,780	25
26	2000 IMPROVEMENTS			2000	832,461	449	VARIOUS	449		831,497	26
27	2001 IMPROVEMENTS			2001	473,208		VARIOUS			473,208	27
28	2002 IMPROVEMENTS			2002	1,911,073	3,303	VARIOUS	3,303		1,895,383	28
29	2003 IMPROVEMENTS			2003	376,034	1,770	VARIOUS	1,770		366,887	29
30	2004 IMPROVEMENTS			2004	165,176		VARIOUS			165,176	30
31	2005 IMPROVEMENTS			2005	159,736		VARIOUS			159,736	31
32	2006 IMPROVEMENTS			2006	2,638,576	155,598	VARIOUS	155,598		1,787,169	32
33	2009 IMPROVEMENTS			2009	29,808	1,106	VARIOUS	1,106		27,780	33
34	2010 IMPROVEMENTS			2010	1,859,660	120,561	VARIOUS	120,561		953,101	34
35	2011 IMPROVEMENTS			2011	404,693	34,254	VARIOUS	34,254		279,195	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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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	BARCO JOINTS	2012	$ 6,568	$ 663	10	$ 657	$ (6)	$ 3,364	37
38	CABLE INSTALLATION FOR WIRELES	2012	75,762		5			75,762	38
39	CABLING FOR RESIDENTS TV'S	2012	65,956		5			65,956	39
40	DAYROOM SURVEY DOCUMENTS	2012	19,945	2,013	10	1,995	(19)	10,382	40
41	FLOORING INSTALLATION - NORTH	2012	10,919		5			10,919	41
42	FURNISH/INST PIPES, HOT WATER	2012	30,063		5			30,063	42
43	MAT./INSTALL LAUNDRY BARCO JOI	2012	8,027	810	10	803	(7)	4,178	43
44	RESIDENT DINING ROOM FLOORING	2012	52,255		5			52,255	44
45	ROOF REPAIR & ROOF WALK INSTAL	2012	51,079	5,156	10	5,108	(48)	26,160	45
46	VARIOUS FLOORING PROJECTS	2012	28,994		5			28,994	46
47	WELLNESS CENTER FLOORING	2012	14,698		5			14,698	47
48	WINDOW REPLACEMENT	2012	20,549	2,074	10	2,055	(19)	10,524	48
49	WINDOW REPLACMENT	2012	5,915		5			5,915	49
50									50
51	FURNISH & INSTALL HANDRAILS	2013	16,600	1,675	10	1,660	(15)	8,085	51
52	FURNISH/INSTALL HANDRAILS STAI	2013	10,000	2,041	5	2,000	(41)	10,000	52
53	NURSE CALL SYSTEM	2013	79,067	16,081	5	15,813	(268)	65,666	53
54	REPLACEMENT FLOORING	2013	26,686	2,691	10	2,669	(22)	10,989	54
55	SMOKER'S SHELTER	2013	3,835	782	5	767	(15)	3,640	55
56	TIMBER ROOF TERRACE REPLACE	2013	68,616	6,919	10	6,862	(57)	28,254	56
57	WELLNESS CENTER RENOVATION	2013	68,211	6,878	10	6,821	(57)	28,087	57
58	WELLNESS CENTER SECURITY ADD	2013	4,400	444	10	440	(4)	1,812	58
59									59
60	Induction Air Terminal Replace	2014	4,840	484	10	484		1,573	60
61	Nurse Call Sys-Rayland Respond	2014	76,082	7,608	10	7,608		27,263	61
62	Replace Flring Various Locatio	2014	39,241	3,924	10	3,924		15,042	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 28,148,959	$ 473,664		$ 473,086	$ (579)	$ 27,692,828	70

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

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 28,148,959	$ 473,664		$ 473,086	$ (578)	$ 27,692,828	1
2	Accordian Folding Door/Install	2015	7,360	1,472	5	1,472		3,067	2
3	Bathroom Flr Upgrades/Res Unit	2015	26,595	1,330	20	1,330		3,214	3
4	Emergency O2 Back Up Bank-1Eas	2015	4,000	200	20	200		483	4
5	Fabricate/Ins Metal Roof Slope	2015	9,800	490	20	490		1,225	5
6	Kitchen Redesign/Renovation	2015	5,525,186	276,259	20	276,259		575,540	6
7	O2 Isolation Valves & Cabinets	2015	37,492	1,875	20	1,875		4,687	7
8	O2 Manifold Replacement	2015	11,485	2,297	5	2,297		4,785	8
9	Porte Cochere - Front Entrance	2015	355,282	17,764	20	17,764		37,009	9
10	Resident Room Rehab	2015	689,337	35,051	20	34,467	(584)	73,023	10
11	Roof Protecti-Leaks/Lightening	2015	3,580	358	10	358		955	11
12	ROOF REPLACEMENT	2015	11,464	573	20	573		1,194	12
13	Smoke Detector Replacements	2015	54,400	10,880	5	10,880		22,667	13
14									14
15	Elevator Emergency Light/Alarm	2016	3,287	657	5	657		767	15
16	Lighting, Outdoor Ed. Area	2016	1,810	362	5	362		392	16
17	Roof Repair	2016	27,654	2,765	10	2,765		2,996	17
18									18
19	KennethMoy DuPage Care CtrSign	2017	3,240	432	5	432		432	19
20	Outdoor Education Project	2017	46,144	385	10	385		385	20
21	Roof Repair & Replacement	2017	182,500	1,521	10	1,521		1,521	21
22	S & E Wing Window Replacements	2017	664,110		10				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)		$ 35,813,685	$ 828,335		$ 827,173	$ (1,162)	$ 28,427,170	34

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

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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	$ 372,095	$ 52,610	$ 52,610	$	VARIOUS	$ 120,665	71
72	Current Year Purchases	16,857	1,080	1,080		5	1,080	72
73	Fully Depreciated Assets	4,897,072				VARIOUS	4,897,072	73
74								74
75	TOTALS	$ 5,286,024	$ 53,690	$ 53,690	$		$ 5,018,817	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	$	$	$	VARIOUS	$ 112,026	76
77	Maint and Transport	2010 Ford F-250	2010	32,280				5	32,280	77
78	Maint and Transport	2010 Ford F-550	2010	77,015				5	77,015	78
79	Maint and Transport	2011 Extended Length Van	2011	31,300				5	31,300	79
80	TOTALS			$ 252,621	$	$	$		$ 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)	$ 42,146,690	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 882,025	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 880,863	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,162)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 33,698,608	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		$	92
93			93
94			94
95		$	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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 163,432 Description: See PG14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

DuPage Convalescent Center
Medicaid Provider Number: 0008201
Medicare Provider Number: 14-5050
FYE: 11/30/2017
Movable Equipment Rental

Account	Vendor	Rental	Amount
2000-53410	Toshiba America Bus S	Copier Rental	50,344
2025-53410	American Compressed Gase	C02 Tank Rental	66
2025-53410	Ecolab Inc.	Dish Machine Conveyor	4,559
2035-53410	Medco Equipment Inc.	Wheelchair Washer Rental	2,340
2050-53410	Advacare Systems	Air Matress', Air Therapy Beds, CPM Mac	67,861
2050-53410	First Biomedical Inc	Infusion Pumps	204
2050-53410	Fitzsimmons Hospital Services	Smart Vest Rental	2,633
2050-53410	Hill-ROM	Bed Rentals	4,770
2050-53410	Intragrated Healthcare Equipment	Low Air Mattress	143
2050-53410	Medical Specialties	Pump Rentals	5,987
2050-53410	PEL/VIP Medical Staffing	Respiratory Equipment	14,483
2075-53410	Airgas USA LLC	Oxygen Rental	8,188
2075-53410	Praxair Distribution		1,854
Grand Total			163,432

2000-53410	50,344
2025-53410	4,625
2035-53410	2,340
2050-53410	96,081
2075-53410	10,042
	163,432

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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 Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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	V39-4	61,274	# of prescrpts	1,859,656				61,274	1,859,656	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				$ 1,859,656		$	$	61,274	$ 1,859,656	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.

DuPage Convalescent Center
Medicaid Provider Number: 0008201
Medicare Provider Number: 14-5050
FYE: 11/30/2017
Pharmacy Cost

Payor	Pharmacy Charges	Medication Costs
Medicaid	92,245	83,995
Medicare Part	2,148,341	1,483,405
Private	323,207	84,300
Medicare	560,384	176,729
Insurance	53,459	24,711
Hospice	8,460	6,515
Grand Total	3,186,095	1,859,656

# of prescriptions	77,110	Inpatient
	3,795	Outpatient
	80,905	

Prepared by:

Dale Wagener
Pharmacy Manager

STATE OF ILLINOIS

Facility Name & ID Number Du Page Care Center **#** 0008201 **Report Period Beginning:** 12/01/2016 **Ending:** 11/30/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/2017 **(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	$ 1,957,313	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,568,892)	20,435,845		3
4	Supply Inventory (priced at)	309,852		4
5	Short-Term Investments	(22,321)		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	30,994		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 22,711,683	$	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	38,751,832		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,538,645		16
17	Accumulated Depreciation (book methods)	(33,698,608)		17
18	Deferred Charges	(785,922)		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)**	$ 10,590,307	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 33,301,990	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,131,742	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,090,148		30
31	Accrued Taxes Payable (excluding real estate taxes)	249,229		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	5,822,304		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,293,423	$	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	3,619,973		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,619,973	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,913,396	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 21,388,594	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 33,301,990	$	48

***(See instructions.)**

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 19,525,038	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 19,525,038	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,429,772)	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) **Contributed Capital**	8,293,328	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,863,556	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)**	$ 21,388,594	24 *

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

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 32,510,445	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 32,510,445	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	771,390	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,508,445	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	1,230	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,281,065	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30,485	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,485	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See PG19A	331,106	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 331,106	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 35,153,101	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	5,523,324	31
32	Health Care	18,417,625	32
33	General Administration	8,666,191	33
	B. Capital Expense		
34	Ownership	1,045,457	34
	C. Ancillary Expense		
35	Special Cost Centers	3,512,431	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Indirect Expenses	4,417,845	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 41,582,873	40
41	**Income before Income Taxes (line 30 minus line 40)****	(6,429,772)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (6,429,772)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 18,212,408	44
45	Private Pay - Net Inpatient Revenue	10,268,187	45
46	Medicare - Net Inpatient Revenue	4,029,850	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 32,510,445	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: 11/30/2017
Non Operating Revenue

Acct	Description	Category Non Op Rev	Reported separetly on Page 19 or Page 18	Other Non Oper Revenue	
42000	Service Fee	(9,755)		(9,755)	
42080	Wellness Center Fee	(26,091)		(26,091)	
42081	Convo Cafeteria Earnings	(270,198)	(270,198)	-	
42082	JTK Cafeteria Earnings	(85,103)	(85,103)	-	
42083	JOF Cafeteria Earnings	(279,034)	(279,034)	-	
42085	Catering Service Earnings	(137,055)	(137,055)	-	
42086	Vending Machine Earnings	9,759		9,759	
42087	Campus Cleaning Service Fee	(161,542)		(161,542)	
42088	Laundry Service Reimb Fee	(1,230)	(1,230)	-	
45000	Investment Income	(30,485)	(30,485)	-	
46000	Contrubuted Capital	-	-	-	Reported on PG 18
46000	Miscellaneous Revenue	(31,446)		(31,446)	
46006	Refunds and Overpayments	(29,728)		(29,728)	
46030	Other Reimbursements	(82,477)		(82,477)	
47000	Transfer In General Fund	-	-	-	Reported on PG 18
47106	Loss on Disposal of Assets	174		174	Reported on PG 18
Grand Total		(1,134,211)	(803,105)	(331,106)	To Be Transferred to line 28A - Page 19

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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	1,809	2,334	$ 162,488	$ 69.62	1
2	Assistant Director of Nursing	3,409	3,717	158,983	42.77	2
3	Registered Nurses	111,631	197,987	4,588,367	23.18	3
4	Licensed Practical Nurses	36,215	66,624	1,135,803	17.05	4
5	CNAs & Orderlies	379,099	657,611	7,134,978	10.85	5
6	CNA Trainees					6
7	Licensed Therapist	1,680	1,946	76,604	39.36	7
8	Rehab/Therapy Aides	23,251	27,869	532,120	19.09	8
9	Activity Director	1,643	1,909	51,112	26.77	9
10	Activity Assistants	20,225	23,382	450,246	19.26	10
11	Social Service Workers	12,432	14,625	376,562	25.75	11
12	Dietician	5,368	6,187	140,821	22.76	12
13	Food Service Supervisor	1,699	1,983	51,685	26.06	13
14	Head Cook	9,909	13,308	204,410	15.36	14
15	Cook Helpers/Assistants	69,406	75,268	1,046,929	13.91	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	77,666	93,338	1,199,165	12.85	18
19	Laundry	26,119	29,328	360,378	12.29	19
20	Administrator	1,767	2,139	163,383	76.38	20
21	Assistant Administrator	3,529	4,120	219,567	53.29	21
22	Other Administrative	10,633	12,463	315,920	25.35	22
23	Office Manager					23
24	Clerical	14,119	16,581	381,269	22.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	8,678	9,991	207,507	20.77	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,261	4,905	101,800	20.75	31
32	Other Health Care(specify)	92,428	130,044	2,194,581	16.88	32
33	Other(specify) Ancillary Services					33
34	TOTAL (lines 1 - 33)	916,976	1,397,659	$ 21,254,678 *	$ 15.21	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	571	$ 33,234	10-3	50
51	Licensed Practical Nurses	6,286	289,285	10-3	51
52	Certified Nurse Assistants/Aides	7,603	199,388	10-3	52
53	TOTAL (lines 50 - 52)	14,460	$ 521,907		53

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Ulmer	Administrator	None	$ 163,383
Support Staff	Support Staff	None	507,778
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 671,161

B. Administrative - Other

Description	Amount
See Trial Balance Detail	$ 181,180
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 181,180

C. Professional Services

Vendor/Payee	Type	Amount
CliftonLarsonAllen LLP	Auditing & Accounting	$ 7,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 7,000

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 479,420
Unemployment Compensation Insurance	18,093
FICA Taxes	1,423,713
Employee Health Insurance	3,355,910
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	2,143,099
Tuition Reimbursement	8,280
TOTAL (agree to Schedule V, line 22, col.8)	$ 7,428,515

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,266
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
LeadingAge Illinois	27,954
Other Dues	2,110
Less: Public Relations Expense	( )
Non-allowable advertising	(3,266)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,064

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,296
Seminar Expense	21,053
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,349

**See instructions.

Final Notice of Illinois Municipal Retirement Fund Contribution Rate for Calendar Year 2017

Date November 2016

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	5.89%	11.88%	16.84%
Funding Adjustment <over> under	4.99%	11.74%	55.48%
Net Retirement Rate	10.88%	23.62%	72.32%
• **Other Program Benefits**			
Death	0.13%	0.13%	0.15%
Disability	0.12%	0.12%	0.12%
Supplemental Benefit Payment	0.62%	0.62%	0.62%
Early Retirement Incentive	0.00%	0.00%	0.00%
SLEP Enhancement	0.00%	1.18%	0.00%
• **TOTAL EMPLOYER RATE**	11.75%	25.67%	73.21%

DUPAGE COUNTY
JOANNE S. UITTO, MANAGER OF BENEFITS & PAYROLL
421 N COUNTY FARM RD
WHEATON IL 60187-3992

Facility Name & ID Number Du Page Care Center # 0008201 Report Period Beginning: 12/01/2016 Ending: 11/30/2017

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 $27,954**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **245,017** 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. $ **878,989**
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. $ **771,390**

(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:

(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