FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0008201

Facility Name: DuPage 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: 1/1/1935

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Deb Emerson **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 12/1/2019 to 11/30/2020 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) Deb Emerson, 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 DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	94,197	7,606	3,790	105,593	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	94,197	7,606	3,790	105,593	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.40%

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 1/1/1938

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 3,419

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: 11/30/20 Fiscal Year: 11/30/20

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

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	1,236,880	64,621	3,303	1,304,804		1,304,804		1,304,804			1
2	Food Purchase		828,113		828,113		828,113	(284,419)	543,694			2
3	Housekeeping	1,286,718	122,205	48,464	1,457,387		1,457,387	(205,380)	1,252,007			3
4	Laundry	313,621	127,248	2,724	443,593		443,593		443,593			4
5	Heat and Other Utilities			811,793	811,793		811,793	1,431,637	2,243,430			5
6	Maintenance		(200)	108,920	108,720		108,720	114,893	223,613			6
7	Other (specify):*											7
8	TOTAL General Services	2,837,219	1,141,987	975,204	4,954,410		4,954,410	1,056,731	6,011,141			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	12,422,518	64,397	941,351	13,428,266		13,428,266		13,428,266			10
10a	Therapy	518,207	28,244	728,322	1,274,773	(1,274,773)						10a
11	Activities	493,553	7,312	235	501,100		501,100		501,100			11
12	Social Services	670,802	2,678	6,214	679,694		679,694		679,694			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	14,105,080	102,631	1,676,122	15,883,833	(1,274,773)	14,609,060		14,609,060			16
	C. General Administration											
17	Administrative	705,480	61,326	437,236	1,204,042		1,204,042	1,551,863	2,755,905			17
18	Directors Fees											18
19	Professional Services			16,379	16,379		16,379	144,787	161,166			19
20	Dues, Fees, Subscriptions & Promotions			58,233	58,233		58,233		58,233			20
21	Clerical & General Office Expenses	428,497	55,182	458,872	942,551		942,551	(454,021)	488,530			21
22	Employee Benefits & Payroll Taxes			6,800,170	6,800,170		6,800,170	321,065	7,121,235			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,513	5,513		5,513		5,513			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							358,699	358,699			26
27	Other (specify):*											27
28	TOTAL General Administration	1,133,977	116,508	7,776,403	9,026,888		9,026,888	1,922,392	10,949,280			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	18,076,276	1,361,126	10,427,729	29,865,131	(1,274,773)	28,590,358	2,979,123	31,569,481			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 DuPage Care Center #0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			877,980	877,980		877,980	(41,816)	836,164			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			223,598	223,598	(159,656)	63,942		63,942			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,101,578	1,101,578	(159,656)	941,922	(41,816)	900,106			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	725,242	2,385,482	212,405	3,323,129	1,434,429	4,757,558	(21,707)	4,735,851			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							821,773	821,773			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	725,242	2,385,482	212,405	3,323,129	1,434,429	4,757,558	800,066	5,557,624			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	18,801,518	3,746,608	11,741,712	34,289,838		34,289,838	3,737,373	38,027,211			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 DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	(454,021)	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	(7,223)	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	4,198,617			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 3,737,373		$	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))**	$ 3,737,373		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		590,201	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 590,201		47

DuPage Care Center

ID# 0008201

Report Period Beginning: 12/1/2019

Ending: 11/30/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing - Administration	$ (255)	17	1
2	Cafeteria Income	(284,419)	2	2
3	Campus Cleaning Svc Income	(205,380)	3	3
4	Misc Revenue	(198,269)	17	4
5	Refunds & Overpayments	(24,637)	17	5
6	Wellness Center Income	(14,484)	39	6
7	Provider Participation Fees Exp	821,773	42	7
8	Service Fee Income	(19,020)	17	8
9				9
10	DuPage County Cost Alloc - Heating/Utilities	1,431,637	5	10
11	DuPage County Cost Alloc - Equip Repair/Maint	114,893	6	11
12	DuPage County Cost Alloc - Administration	1,794,044	17	12
13	DuPage County Cost Alloc - Employee Benefits	321,065	22	13
14	DuPage County Cost Alloc - Prof. Liability Ins.	358,699	26	14
15	DuPage County Cost Alloc - Equipment Lease	0	35	15
16	DuPage County Cost Alloc - Professional	144,787	19	16
17				17
18	Prior Year Desk Audit Depreciation Impact	(41,816)	30	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**	4,198,617		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	(284,419)	0	0	0	0	0	0	0	0	0	0	(284,419)	2
3	Housekeeping	(205,380)	0	0	0	0	0	0	0	0	0	0	(205,380)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	1,431,637	0	0	0	0	0	0	0	0	0	0	1,431,637	5
6	Maintenance	114,893	0	0	0	0	0	0	0	0	0	0	114,893	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,056,731	0	0	0	0	0	0	0	0	0	0	1,056,731	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	1,551,863	0	0	0	0	0	0	0	0	0	0	1,551,863	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	144,787	0	0	0	0	0	0	0	0	0	0	144,787	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(454,021)	0	0	0	0	0	0	0	0	0	0	(454,021)	21
22	Employee Benefits & Payroll Taxes	321,065	0	0	0	0	0	0	0	0	0	0	321,065	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	358,699	0	0	0	0	0	0	0	0	0	0	358,699	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	1,922,392	0	0	0	0	0	0	0	0	0	0	1,922,392	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	2,979,123	0	0	0	0	0	0	0	0	0	0	2,979,123	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DuPage Care Center **#** 0008201 **Report Period Beginning:** 12/1/2019 **Ending:** 11/30/2020

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

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(41,816)	0	0	0	0	0	0	0	0	0	0	(41,816)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(41,816)	0	0	0	0	0	0	0	0	0	0	(41,816)	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	(21,707)	0	0	0	0	0	0	0	0	0	0	(21,707)	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	821,773	0	0	0	0	0	0	0	0	0	0	821,773	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	800,066	0	0	0	0	0	0	0	0	0	0	800,066	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,737,373	0	0	0	0	0	0	0	0	0	0	3,737,373	45

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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 Care 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 DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	Puchalski, Donald E.	BOD						1
2	Selmon, Ashley	BOD						2
3	Tornatore, Sam	BOD						3
4	Chaplin, Elizabeth	BOD						4
5	DiCianni, Peter	BOD						5
6	Garcia, Paula	BOD						6
7	Hart, Greg	BOD						7
8	Krajewski, Brian J.	BOD						8
9	Renehan, Julie	BOD						9
10	Eckhoff, Grant	BOD						10
11	LaPlante, Lynn	BOD						11
12	Ozog, Mary FitzGerald	BOD						12
13	Covet, Sadia	BOD						13
14	DeSart, Dawn	BOD						14
15	Chavez, Amy	BOD						15
16	Schwarze, Greg	BOD						16
17	Rutledge, Sheila	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 DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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 DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 1/30/2020

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 ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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: 11/30/2020
Indirect Cost Accruals: 1200-2020 Convalescent Center Operating Fund

Expenditure Object	Description	FY2020 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	93,680	Prof	-
53000	1000-1150 Finance-Gen Acct/Budgeting	30,823	Prof	-
53000	1000-1170 Audit	-	Prof	-
53000	1000-4000 County Auditor	20,284	Prof	-
53020	1000-1110 IT Svc	950,313		950,313
53090	1000-1150 Finance-Purchasing	124,239		124,239
53090	1000-1180 Spec Accts	-		-
53090	1100-1212 Liability Insurance	-		-
53100	1100-1212 Liability Insurance	3,349		3,349
53110	1100-1212 Liability Insurance	311,448	EB	-
53120	1000-1200 Corporate Fund Ins	22,881		22,881
53130	1100-1212 Liability Insurance	338,554	Prof Liab	-
53140	1100-1212 Liability Insurance	8,179	Prof Liab	-
53160	1100-1212 Liability Insurance	9,617	EB	-
53170	1100-1212 Liability Insurance	11,920	Prof Liab	-
53230	1000-1100 Facilities Mgmt - Utilities	77		77
53250	1000-1110 Wired Communication Svcs	-		-
53300	1000-1100 Facilities Mgmt - Bldg Mtce	-		-
53300	1000-1100 Facilities Mgmt - Pwr Plant	1,431,637	H/U	-
53300	1000-1100 Facilities Mgmt-Space	-		-
53370	1000-1180 Spec Accts	1,897	r&m	-
53410	1000-1150 Finance - Pager Rental	-	EL	-
53410	1000-1180 Spec Accts	-		-
53610	1100-1212 Liability Insurance	46	Prof Liab	-
53800	1000-1110 Printing	-		-
53803	1000-1180 Spec Accts	-		-
53804	1000-1150 Finance-Mailroom	9,553		9,553
53808	1000-1180 Spec Accts	40		40
53809	1000-1130 Personnel-Security	363,941		363,941
53812	1500-3530 Roads & Grounds	112,996	r&m	-
53815	1000-1001 County Board	18,784		18,784
53830	1000-1120 Personnel	296,677		296,677
53830	1000-1180 Spec Accts	4,188		4,188
Grand Total		4,165,124		1,794,044 total admin

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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. $ _____ Line # _____

* 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 DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DuPage 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 2019 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 2019.

	(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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	$ 784,360	1
2					2
3	TOTALS	400,000		$ 784,360	3

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	$ 4,456,548	$	30	$	$	$ 4,456,548	4
5	148		1947	1947	70,858		5			70,858	5
6	16		1979	1979	1,750,524		30			1,750,524	6
7			1964	1983	1,172,064		34			1,172,064	7
8	100		1993	1993	6,516,821	76,989	VARIOUS	76,989		5,539,391	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			1989	199,883		VARIOUS			199,883	16
17	1990 IMPROVEMENTS			1990	5,423		VARIOUS			5,423	17
18	1992 IMPROVEMENTS			1992	604,207		VARIOUS			604,208	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			35,064	21
22	1996 IMPROVEMENTS			1996	4,356		VARIOUS			4,356	22
23	1997 IMPROVEMENTS			1997	320,587		VARIOUS			320,587	23
24	1998 IMPROVEMENTS			1998	10,922		VARIOUS			10,922	24
25	1999 IMPROVEMENTS			1999	701,043		VARIOUS			701,043	25
26	2000 IMPROVEMENTS			2000	832,461		VARIOUS			832,461	26
27	2001 IMPROVEMENTS			2001	473,208		VARIOUS			473,208	27
28	2002 IMPROVEMENTS			2002	1,911,074	3,272	VARIOUS	3,272		1,905,017	28
29	2003 IMPROVEMENTS			2003	376,034	872	VARIOUS	872		369,818	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	90,121	VARIOUS	90,121		2,101,918	32
33	2009 IMPROVEMENTS			2009	29,808	8,071	VARIOUS		(8,071)	594,216	33
34	2010 IMPROVEMENTS			2010	1,859,660	59,669	VARIOUS	59,669		691,461	34
35	2011 IMPROVEMENTS			2011	404,694	25,320	VARIOUS	25,320		379,103	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 DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	2012 IMPROVEMENTS	2012	$ 390,730	$ 10,617	VARIOUS	$ 10,617	$	$ 370,426	37
38	2013 IMPROVEMENTS	2013	277,415	18,451	VARIOUS	18,451		224,400	38
39	2014 IMPROVEMENTS	2014	120,163	12,016	VARIOUS	12,016		78,925	39
40	Bathroom Flr Upgrades/Res Unit	2015	26,595	1,330	20	1,330		7,092	40
41	Emergency O2 Back Up Bank-1Eas	2015	4,000	200	20	200		1,067	41
42	Fabricate/Ins Metal Roof Slope	2015	9,800	490	20	490		2,654	42
43	Kitchen Redesign/Renovation	2015	5,525,186	276,259	20	276,259		1,381,297	43
44	O2 Isolation Valves & Cabinets	2015	37,492	1,875	20	1,875		10,154	44
45	Porte Cochere - Front Entrance	2015	355,282	17,764	20	17,764		88,821	45
46	Resident Room Rehab	2015	598,725	34,467	20	29,936	(4,531)	175,255	46
47	Roof Protecti-Leaks/Lightening	2015	3,580	358	10	358		1,999	47
48	ROOF REPLACEMENT	2015	11,464	573	20	573		2,866	48
49	Elevator Emergency Light/Alarm	2016	3,287	548	5	548		2,684	49
50	Lighting, Outdoor Ed. Area	2016	1,810	332	5	332		1,448	50
51	Roof Repair	2016	27,654	2,765	10	2,765		11,062	51
52	KennethMoy DuPage Care CtrSign	2017	3,240	648	5	648		2,322	52
53	Outdoor Education Project	2017	46,144	4,614	10	4,614		13,843	53
54	Roof Repair & Replacement	2017	182,500	18,250	10	18,250		54,750	54
55	S & E Wing Window Replacements	2017	664,110	66,411	10	66,411		199,233	55
56	Entrance Awnings & Awning Walls	2018	5,200	1,040	5	1,040		2,687	56
57	Roof Repair/Restoration	2018	164,716	16,472	10	16,472		37,821	57
58	Fencing for Garden Courtyard	2018	11,628	2,326	5	2,326		5,426	58
59	Roof Restoration	2018	18,275	3,655	5	3,655		7,310	59
60	Resurface and Stripe Care Center Parking Lot	2018	18,180	3,636	5	3,636		7,272	60
61	Emergency Generator SNF	2019	295,000	29,500	10	29,500		29,500	61
62									62
63	Prior years missed depreciation			29,214			(29,214)	404,756	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 36,159,222	$ 818,125		$ 776,309	$ (41,816)	$ 30,920,858	70

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

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	$ 408,619	$ 56,980	$ 56,980	$		$ 144,693	71
72	Current Year Purchases	115,756	2,875	2,875			789	72
73	Fully Depreciated Assets	2,471,627					2,471,627	73
74								74
75	TOTALS	$ 2,996,002	$ 59,855	$ 59,855	$		$ 2,617,109	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/01 Window Van	1997 - 2001	$ 102,031	$	$	$		$ 102,031	76
77	Maint and Transport	2010 Ford F-250		32,280					32,280	77
78	Maint and Transport	2010 Ford F-550		77,015					77,015	78
79	Maint and Transport	2011 Extended Length Van		31,300					31,300	79
80	TOTALS			$ 242,626	$	$	$		$ 242,626	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)	$ 40,182,210	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 877,980	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 836,164	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (41,816)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 33,780,593	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		$	$	$	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 DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 223,598 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: 11/30/2020
Movable Equipment Rental

Account	Vendor	Rental	Amount
2000-53410	Toshiba America Bus S	Copier Rental	32,101.42
2025-53410	American Compressed Gase	C02 Tank Rental	156.00
2025-53410	Ecolab Inc.	Dish Machine Conveyor	4,559.40
2035-53410	Medco Equipment Inc.	Wheelchair Washer Rental	2,340.00
2050-53410	Advacare Systems	Air Matress', Air Therapy Beds, CPM Machine, Leg & Foot Pumps	109,271.75
2050-53410	Baxter Rental		556.98
2050-53410	First Biomedical Inc	Infusion Pumps	6,718.58
2050-53410	Fitzsimmons Hospital Services	Smart Vest Rental	-
2050-53410	Hill-ROM	Bed Rentals	-
2050-53410	Intragrated Healthcare Equipme	Low Air Mattress	1,659.00
2050-53410	Joerns Woundco Holdings	Bed Rentals	18,991.74
2050-53410	KCI USA Inc	Wound Vaccuum	2,374.56
2050-53410	Pulmonary Exchange LTD	Respiratory Equipment	18,808.00
2050-53410	Zoll Medical Corporation	Vest Defibluatory	-
2060-53410	Accelerated Care Plus LE	Therapy Equipment Rental	12,584.91
2075-53410	Airgas Inc	Oxygen Rental	6,450.00
2075-53410	Praxair Distribution Inc		7,026.25
			223,598.59

2000-53410	32,101
2025-53410	4,715
2035-53410	2,340
2050-53410	158,381
2060-53410	12,585
2075-53410	13,476
	223,598.59

159,656.00 re-class to Ancillary (Line 39)

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts	1,871,558					1,871,558	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			$ 1,871,558		$	$		$ 1,871,558	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2020 (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	$ 12,412,097	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500,000)	19,915,743		3
4	Supply Inventory (priced at)	393,237		4
5	Short-Term Investments	318,944		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	34,303		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 33,074,324	$	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	39,357,985		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,238,629		16
17	Accumulated Depreciation (book methods)	(33,780,593)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Care Center Dining	44,684		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,645,065	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 42,719,389	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 992,315	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,609,071		30
31	Accrued Taxes Payable (excluding real estate taxes)	307,072		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	17,246,884		35
	Other Current Liabilities(specify):			
36	Due to Other Funds	22,566		36
37	Deferred Revenue	(11,088,060)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,089,848	$	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	1,992,182		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,992,182	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,082,030	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 31,637,359	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 42,719,389	$	48

***(See instructions.)**

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 20,883,397	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 20,883,397	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,597,439	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)	8,156,523	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 10,753,962	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)**	$ 31,637,359	24 *

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

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	$ 35,917,968	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 35,917,968	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	284,419	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,537,702	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	1,292	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,823,413	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	215,929	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 215,929	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See PG19A	3,095,090	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,095,090	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 41,052,400	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,954,410	31
32	Health Care	15,883,833	32
33	General Administration	9,026,888	33
	B. Capital Expense		
34	Ownership	1,101,578	34
	C. Ancillary Expense		
35	Special Cost Centers	3,323,129	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Indirect Expenses	4,165,123	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 38,454,961	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,597,439	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,597,439	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 25,540,629	44
45	Private Pay - Net Inpatient Revenue	7,376,078	45
46	Medicare - Net Inpatient Revenue	3,001,261	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 35,917,968	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: 11/30/2020
Other Income

Acct	Description	Category Other Income
41004	Other Federal Reimbursement	(2,553,151)
42000	Service Fee	(19,020)
42080	Wellness Center Fee	(14,484)
42087	Campus Cleaning Service Fee	(205,380)
46000	Miscellaneous Revenue	(198,269)
46006	Refunds and Overpayments	(24,637)
46030	Other Reimbursements	(80,149)
Grand Total		(3,095,090) To Be Transferred to line 28 - Page 19

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,729	2,026	$ 127,289	$ 62.83	1
2	Assistant Director of Nursing	3,319	3,907	184,382	47.19	2
3	Registered Nurses	121,784	224,055	5,104,597	22.78	3
4	Licensed Practical Nurses	36,678	68,221	1,144,258	16.77	4
5	CNAs & Orderlies	247,732	455,192	5,499,850	12.08	5
6	CNA Trainees					6
7	Licensed Therapist	1,762	1,953	76,778	39.31	7
8	Rehab/Therapy Aides	19,279	25,017	483,456	19.33	8
9	Activity Director	2,999	3,648	121,102	33.20	9
10	Activity Assistants	16,137	20,012	381,570	19.07	10
11	Social Service Workers	13,701	16,661	451,303	27.09	11
12	Dietician	5,214	5,945	122,778	20.65	12
13	Food Service Supervisor	4,891	6,191	250,554	40.47	13
14	Head Cook	9,408	13,203	200,926	15.22	14
15	Cook Helpers/Assistants	52,155	57,184	702,370	12.28	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	84,840	101,648	1,320,400	12.99	18
19	Laundry	22,565	26,220	314,676	12.00	19
20	Administrator	1,649	1,959	165,156	84.31	20
21	Assistant Administrator	3,349	3,991	223,873	56.09	21
22	Other Administrative	18,321	23,410	549,947	23.49	22
23	Office Manager					23
24	Clerical	15,169	17,891	435,387	24.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	9,483	10,414	223,922	21.50	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,400	4,189	92,285	22.03	31
32	Other Health C: Other Ancillary	31,516	37,149	624,659	16.81	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	727,080	1,130,086	$ 18,801,518 *	$ 16.64	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	688	$ 43,577	V10-3	50
51	Licensed Practical Nurses	523	28,191	V10-3	51
52	Certified Nurse Assistants/Aides	21,022	753,395	V10-3	52
53	TOTAL (lines 50 - 52)	22,233	$ 825,163		53

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janelle Chadwick	Administrator	None	$ 165,156
Support Staff	Support Staff	None	540,324
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 705,480

B. Administrative - Other

Description	Amount
See TB Detail	$ 437,236
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 437,236

C. Professional Services

Vendor/Payee	Type	Amount
CliftonLarsonAllen LLP	Accounting	$ 7,695
Kopon Airdo, LLC	Legal Services	8,684
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 16,379

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 311,448
Unemployment Compensation Insurance	9,617
FICA Taxes	1,392,545
Employee Health Insurance	3,180,611
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	2,224,281
Tuition Reimbursement	2,733
TOTAL (agree to Schedule V, line 22, col.8)	$ 7,121,235

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	250
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
LeadingAge Illinois	30,758
Other Dues	27,225
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 58,233

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	121
Seminar Expense	5,392
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,513

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DuPage Care Center # 0008201 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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 - $30,758**

(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. $ **194,094** Line **39**

(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. $ **821,773**
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. $ **284,419**

(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: **Baker Tilley**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

DuPage Convalescent Center
Medicaid Provider Number: 0008201
Medicare Provider Number: 14-5050
FYE: 11/30/2020
Legal Detail

Law Firm	Invoice Date	Amount	Description
Kopon Airdo, LLC	4/30/2020	2,186.87	Regulatory issues & risk management
Kopon Airdo, LLC	4/30/2020	123.13	Regulatory issues & risk management
Kopon Airdo, LLC	5/7/2020	421.38	Regulatory issues & risk management
Kopon Airdo, LLC	5/18/2020	263.73	Regulatory issues & risk management
Kopon Airdo, LLC	6/15/2020	643.98	Regulatory issues & risk management
Kopon Airdo, LLC	8/14/2020	4,449.65	Regulatory issues & risk management
Kopon Airdo, LLC	11/12/2020	595.00	Regulatory issues & risk management
		8,683.74	