FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0049759

Facility Name: WEST SUBURBAN NSG & REHABILITATION CENTER

Address: 311 EDGEWATER DRIVE (Number) BLOOMINGDALE (City) 60108 (Zip Code)

County: DU PAGE

Telephone Number: (630) 894-7400 **Fax #** (630) 894-8528

HFS ID Number:

Date of Initial License for Current Owners: 11/1/07

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: DANIEL S. GAAFAR **Telephone Number:** (317) 237-5500
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 1/1/10 to 12/31/10 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) MOISHE GUBIN
(Title) MANAGER

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT ATTACHED (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY & ASSOCIATES, INC., 201 S. CAPITOL AVE, STE 910, INDIANAPOLIS, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	259	Skilled (SNF)	259	94,535	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	259	TOTALS	259	94,535	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	51,824	4,602	9,102	65,528	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,824	4,602	9,102	65,528	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.32%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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 11/1/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 259 and days of care provided 8,179

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITAT # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	304,355	38,650	15,000	358,005		358,005	(605)	357,400			1
2	Food Purchase		300,225		300,225		300,225		300,225			2
3	Housekeeping	279,340	58,815		338,155		338,155		338,155			3
4	Laundry	69,525	27,069		96,594		96,594		96,594			4
5	Heat and Other Utilities			312,958	312,958		312,958		312,958			5
6	Maintenance	62,536	22,262	44,095	128,893		128,893	(607)	128,286			6
7	Other (specify):*											7
8	TOTAL General Services	715,756	447,021	372,053	1,534,830		1,534,830	(1,212)	1,533,618			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	4,371,132	557,923	37,530	4,966,585		4,966,585	20,367	4,986,952			10
10a	Therapy			745,463	745,463		745,463		745,463			10a
11	Activities	167,704	35,507		203,211		203,211		203,211			11
12	Social Services	88,759		1,012	89,771		89,771		89,771			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharm. Consult.			22,331	22,331		22,331		22,331			15
16	TOTAL Health Care and Programs	4,627,595	593,430	830,336	6,051,361		6,051,361	20,367	6,071,728			16
	C. General Administration											
17	Administrative	90,082			90,082		90,082		90,082			17
18	Directors Fees											18
19	Professional Services			280,360	280,360		280,360	(258,148)	22,212			19
20	Dues, Fees, Subscriptions & Promotions			3,301	3,301		3,301	478	3,779			20
21	Clerical & General Office Expenses	226,637	82,669	13,847	323,153		323,153	49,306	372,459			21
22	Employee Benefits & Payroll Taxes			867,892	867,892		867,892	26,439	894,331			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,158	12,158		12,158	377	12,535			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			136,840	136,840		136,840	88,497	225,337			26
27	Other (specify):*											27
28	TOTAL General Administration	316,719	82,669	1,314,398	1,713,786		1,713,786	(93,051)	1,620,735			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,660,070	1,123,120	2,516,787	9,299,977		9,299,977	(73,896)	9,226,081			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

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 WEST SUBURBAN NSG & REHABILITATION CENTER #0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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			70,713	70,713		70,713	259,658	330,371			30
31	Amortization of Pre-Op. & Org.							392,555	392,555			31
32	Interest			116,590	116,590		116,590	749,987	866,577			32
33	Real Estate Taxes							156,628	156,628			33
34	Rent-Facility & Grounds			1,680,000	1,680,000		1,680,000	(1,679,246)	754			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,867,303	1,867,303		1,867,303	(120,418)	1,746,885			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		546,103		546,103		546,103		546,103			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,803	141,803		141,803		141,803			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		546,103	141,803	687,906		687,906		687,906			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,660,070	1,669,223	4,525,893	11,855,186		11,855,186	(194,314)	11,660,872			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTI # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	(2,466)	30		9
10	Interest and Other Investment Income	(1,850)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(104)	1		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	(30,047)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(41,517)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (75,984)		$	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)	(118,330)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (118,330)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (194,314)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

WEST SUBURBAN NSG & REHABILITATION CENTER

ID# 0049759

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MEDICAL RECORDS INCOME	$ (289)	10	1
2	MISCELLANEOUS INCOME	(40,554)	21	2
3	VENDING INCOME	(674)	6	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				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**	(41,517)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(104)	(501)	0	0	0	0	0	0	0	0	0	(605)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(674)	67	0	0	0	0	0	0	0	0	0	(607)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(778)	(434)	0	0	0	0	0	0	0	0	0	(1,212)	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	(289)	20,656	0	0	0	0	0	0	0	0	0	20,367	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**	(289)	20,656	0	0	0	0	0	0	0	0	0	20,367	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(258,148)	0	0	0	0	0	0	0	0	0	(258,148)	19
20	Fees, Subscriptions & Promotions	0	478	0	0	0	0	0	0	0	0	0	478	20
21	Clerical & General Office Expenses	(70,601)	119,907	0	0	0	0	0	0	0	0	0	49,306	21
22	Employee Benefits & Payroll Taxes	0	26,439	0	0	0	0	0	0	0	0	0	26,439	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	377	0	0	0	0	0	0	0	0	0	377	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	461	88,036	0	0	0	0	0	0	0	0	88,497	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(70,601)	(110,486)	88,036	0	0	0	0	0	0	0	0	(93,051)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,668)	(90,264)	88,036	0	0	0	0	0	0	0	0	(73,896)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTEI # 0049759 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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	(2,466)	0	262,124	0	0	0	0	0	0	0	0	259,658	30
31	Amortization of Pre-Op. & Org.	0	0	392,555	0	0	0	0	0	0	0	0	392,555	31
32	Interest	(1,850)	0	751,837	0	0	0	0	0	0	0	0	749,987	32
33	Real Estate Taxes	0	0	156,628	0	0	0	0	0	0	0	0	156,628	33
34	Rent-Facility & Grounds	0	754	(1,680,000)	0	0	0	0	0	0	0	0	(1,679,246)	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	(4,316)	754	(116,856)	0	0	0	0	0	0	0	0	(120,418)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(75,984)	(89,510)	(28,820)	0	0	0	0	0	0	0	0	(194,314)	45

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Moishe Gubin	37.5%			Infinity Healthcare	Hillside, IL	Management Co.
Michael Blisko	37.5%					
Y&B Investments	20%					
A&F General Realty	5%					

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. [X] 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	1	DIETARY	$ 12,500	INFINITY HEALTHCARE MANAGEMENT		$ 11,999	$ (501)	1
2	V	10	NURSING	21,000	INFINITY HEALTHCARE MANAGEMENT		41,656	20,656	2
3	V	19	PROFESSIONAL SERVICES	274,900	INFINITY HEALTHCARE MANAGEMENT		492	(274,408)	3
4	V	21	OFFICE EXPENSE	6,166	INFINITY HEALTHCARE MANAGEMENT		125,990	119,824	4
5	V	22	EMPLOYEE EXPENSE	3,593	INFINITY HEALTHCARE MANAGEMENT		30,032	26,439	5
6	V	24	AUTO/TRAVEL EXPENSE	372	INFINITY HEALTHCARE MANAGEMENT		749	377	6
7	V	6	MAINTENANCE		INFINITY HEALTHCARE MANAGEMENT		67	67	7
8	V	20	CLASSIFIED ADS		INFINITY HEALTHCARE MANAGEMENT		228	228	8
9	V	26	INSURANCE		INFINITY HEALTHCARE MANAGEMENT		461	461	9
10	V	34	RENT		INFINITY HEALTHCARE MANAGEMENT		754	754	10
11	V	19	PROFESSIONAL SERVICES		WEST SUBURBAN NURSING REALTY		16,260	16,260	11
12	V	20	FILING FEES		WEST SUBURBAN NURSING REALTY		250	250	12
13	V	21	BANK SERVICE CHARGES		WEST SUBURBAN NURSING REALTY		83	83	13
14	Total			$ 318,531			$ 229,021	$ * (89,510)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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. [X] 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)	
15	V	26	LIABILITY INSURANCE	$	WEST SUBURBAN NURSING REALTY		$ 88,036	$ 88,036	15
16	V	30	DEPRECIATION		WEST SUBURBAN NURSING REALTY		262,124	262,124	16
17	V	31	AMORTIZATION		WEST SUBURBAN NURSING REALTY		392,555	392,555	17
18	V	32	MORTGAGE EXPENSE		WEST SUBURBAN NURSING REALTY		751,837	751,837	18
19	V	33	PROPERTY TAX EXPENSE		WEST SUBURBAN NURSING REALTY		156,628	156,628	19
20	V	34	RENT	1,680,000	WEST SUBURBAN NURSING REALTY			(1,680,000)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,680,000			$ 1,651,180	$ * (28,820)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITAT # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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									$		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 WEST SUBURBAN NSG & REHABILITATION CENTEI # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X]

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						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATI # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HEARTLAND BANK		X	HUD LOAN	$75,247.00	7/1/2009	$ 14,450,000	$ 14,238,197	6/30/2049	5.2500	$ 751,838	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MIDWEST BANK		X	WORKING CAPITAL	NONE	4/1/2008	2,000,000	1,590,000	6/7/2010	5.5000	116,590	6
7												7
8												8
9	TOTAL Facility Related				$75,247.00		$ 16,450,000	$ 15,828,197			$ 868,428	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 16,450,000	$ 15,828,197			$ 868,428	15

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

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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 WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 65,282	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.)		$ 158,242	2
3. Under or (over) accrual (line 2 minus line 1).		$ 92,960	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 63,668	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.		$ 156,628	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006		9
2007	146,655	10
2008	153,409	11
2009	158,242	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WEST SUBURBAN NSG & REHABILITATION CENTER COUNTY DU PAGE

FACILITY IDPH LICENSE NUMBER 0049759

CONTACT PERSON REGARDING THIS REPORT DANIEL S. GAAFAR

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-23-124-022	LONG TERM CARE PROPERTY	$ 158,242.40	$ 158,242.40
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 158,242.40	$ 158,242.40

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 X 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,047 B. General Construction Type: Exterior MASONRY Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 194,364
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 12,958
4. Dates Incurred: 2007

Nature of Costs: ORGANIZATIONAL 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	FACILITY		2007	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	259		2007		$ 7,270,000	$ 186,410	39	$ 186,410	$	$ 590,298	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PTAC Unit			2007	2,145	55	39	55		165	9
10	Ceiling Tile, Floor Tile, and Wall Tile			2008	5,720	147	39	147		416	10
11	Ceramic Cove Base			2008	160	4	39	4		11	11
12	Ceiling Tile			2008	255	7	39	7		19	12
13	A/C Unit Roof Top			2008	4,440	114	39	114		323	13
14	Plumbing			2008	7,400	190	39	190		475	14
15	Mortar, Metal Trim, Drywall			2008	399	10	39	10		29	15
16	Mortar, Metal Trim, Drywall			2008	214	5	39	5		15	16
17	Mortar, Metal Trim, Drywall			2008	50	1	39	1		3	17
18	Remodel (1st Floor Shower Room)			2008	3,000	77	39	77		218	18
19	3 A/C Unit Roof Top			2008	2,426	62	39	62		155	19
20	Service Parts for Nurse Call Systems			2008	672	17	39	17		50	20
21	Standby Generator Replacement			2008	900	23	39	23		65	21
22	Roofing Work			2008	1,500	38	39	38		89	22
23	Roofing Work			2008	32,500	833	39	833		1,735	23
24	Generator - 1st Installment			2008	18,013	462	39	462		1,116	24
25	Permit for Generator Work			2008	409	10	39	10		22	25
26	Generator - 2nd Installment			2008	18,013	462	39	462		1,001	26
27	Service Call and Testing for New Generator			2008	697	18	39	18		39	27
28	Adjustment to g/l			2008	(5,700)		39				28
29	Air Conditioner			2009	644	17	39	17		32	29
30	New Carpet			2009	1,164	30	39	30		37	30
31	Dining Room Heater Unit			2009	7,970	204	39	204		408	31
32	New Roof			2009	29,150	747	39	747		1,370	32
33	New Roof			2009	2,130	55	39	55		96	33
34	New Concrete for Entrance			2009	4,760	122	39	122		183	34
35	Dining Room Heater Unit			2010	22,295	572	39	572		572	35
36	Shower Room Floor Tiles			2010	6,819	175	39	160	(15)	160	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Shower Room Wall Tiles	2010	$ 9,803	$ 251	39	$ 230	$ (21)	$ 230	37
38	Corridor Wall Coverings, Stationary Panels, Vinyl Tiles	2010	75,237	1,929	39	1,608	(321)	1,608	38
39	Shower Room Floor Tiles	2010	136	3	39	3	(0)	3	39
40	Carrier 4 Ton Unit w/ Curb Adapter & Other Misc. Materials	2010	6,004	154	39	38	(116)	38	40
41	Draft Inducer Motor Assembly	2010	594	15	39	4	(11)	4	41
42	Shower Remodel - Valves, Faucets, Drywall	2010	3,800	97	39	89	(8)	89	42
43	PVC Pipes, Couplings, & Other Materials	2010	663	17	39	17		17	43
44	Shower Room Supplies - Fittings, Corners, Valves	2010	506	13	39	11	(2)	11	44
45	Shower Room Remodeling	2010	3,600	92	39	77	(15)	77	45
46	Shower Room Remodeling - Facuets, Valves, Paint Prep	2010	3,800	97	39	73	(24)	73	46
47	Sink Installation	2010	250	6	39	5	(1)	5	47
48	Replacement Shower Faucet	2010	200	5	39	4	(1)	4	48
49	Replacement Bricks	2010	1,950	50	39	33	(17)	33	49
50	Sheet Metal & Brick Repairs	2010	950	24	39	22	(2)	22	50
51	Patch to Wall Flashings	2010	350	9	39	5	(4)	5	51
52	Patch to Wall Flashings, Resealed Eams on Granulated Roof	2010	850	22	39	9	(13)	9	52
53	Concrete Sidewalk Repairs	2010	6,850	176	39	102	(74)	102	53
54	Parking Lot Lease Dues	2010	12	0	39	0	(0)	0	54
55	Blacktop Removal/Resurfacing	2010	7,500	192	39	112	(80)	112	55
56	John Brewer - Blacktop Removal/Resurfacing	2010	4,140	106	39	62	(44)	62	56
57	John Brewer - Blacktop Removal/Resurfacing	2010	3,200	82	39	48	(34)	48	57
58	Paint	2010	64	2	39	1	(1)	1	58
59	Surveying	2010	1,250	32	39	16	(16)	16	59
60	Ductwork Repairs in Ceiling	2010	3,964	102	39	42	(60)	42	60
61	Professional Engineering Services for a Parking Lot	2010	10,440	268	39	112	(156)	112	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,584,258	$ 194,614		$ 193,576	$ (1,038)	$ 601,825	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CI # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 665,668	$ 130,220	$ 133,133	$ 2,913	5 YRS	$ 352,947	71
72	Current Year Purchases	40,014	8,003	3,662	(4,341)	5 YRS	3,662	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 705,682	$ 138,223	$ 136,795	$ (1,428)		$ 356,609	75

D. Vehicle Depreciation (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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 8,689,940	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 332,837	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 330,371	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,466)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 958,434	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 WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
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. 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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ ____ Description: ____
(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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	10a-3	hrs	$		$ 274,481	$		$ 274,481	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			119,179			119,179	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			351,803			351,803	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				531,042		531,042	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab, X-Ray, Ambu.	39-2					15,061		15,061	13
14	TOTAL			$		$ 745,463	$ 546,103		$ 1,291,566	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (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	$ 62,842	$ 1,666,461	1
2	Cash-Patient Deposits	(15,251)	(15,251)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,281,534	2,282,034	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	208,597	208,597	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,537,722	$ 4,141,841	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		7,270,000	14
15	Leasehold Improvements, at Historical Cost	314,256	314,256	15
16	Equipment, at Historical Cost	175,683	705,683	16
17	Accumulated Depreciation (book methods)	(113,036)	(968,333)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,048	194,364	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,343)	(32,618)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **NET GOODWILL**		4,496,667	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 381,608	$ 12,380,019	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,919,330	$ 16,521,860	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 848,922	$ 848,922	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	522,478	522,478	30
31	Accrued Taxes Payable (excluding real estate taxes)		38,051	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Settlement Reserve	(6,000)	(6,000)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,365,400	$ 1,403,451	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,590,000	1,590,000	39
40	Mortgage Payable		14,238,197	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,590,000	$ 15,828,197	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,955,400	$ 17,231,648	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (36,070)	$ (709,788)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,919,330	$ 16,521,860	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (173,675)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (173,675)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	237,605	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	(100,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 137,605	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)**	$ (36,070)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION C # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,381,356	1
2	Discounts and Allowances for all Levels	(1,295,718)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,085,638	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,362,209	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,362,209	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	570,131	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,282	19
20	Radiology and X-Ray	1,849	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 582,262	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	691	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 691	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	674	28
28a	MISCELLANEOUS INCOME	61,317	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 61,991	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,092,791	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,534,830	31
32	Health Care	6,051,361	32
33	General Administration	1,713,786	33
	B. Capital Expense		
34	Ownership	1,867,303	34
	C. Ancillary Expense		
35	Special Cost Centers	546,103	35
36	Provider Participation Fee	141,803	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,855,186	40
41	**Income before Income Taxes (line 30 minus line 40)****	237,605	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 237,605	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	1,892	2,094	$ 113,032	$ 53.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	49,514	54,047	1,642,828	30.40	3
4	Licensed Practical Nurses	31,969	35,308	916,702	25.96	4
5	CNAs & Orderlies	117,774	130,692	1,698,570	13.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,513	8,467	167,704	19.81	9
10	Activity Assistants					10
11	Social Service Workers	4,146	4,386	88,759	20.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,665	29,428	304,355	10.34	15
16	Dishwashers					16
17	Maintenance Workers	3,785	4,275	62,536	14.63	17
18	Housekeepers	26,242	29,097	279,340	9.60	18
19	Laundry	7,454	8,275	69,525	8.40	19
20	Administrator	2,083	2,187	90,082	41.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,503	11,578	226,637	19.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	289,540	319,834	$ 5,660,070 *	$ 17.70	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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	429	$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	751	37,530	10-3	38
39	Pharmacist Consultant	447	22,331	15-3	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	29	1,012	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,656	$ 75,873		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CI # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MIKE PETTINATI	ADMIN	0%	$ 90,082
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,082

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Bradley & Associates	Accounting	$ 11,102
Johnson, Goldberg…	Accounting	2,750
Infinity Healthcare	Management	266,508
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 280,360

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 176,986
Unemployment Compensation Insurance	59,829
FICA Taxes	431,800
Employee Health Insurance	165,116
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
UNIFORMS	1,527
LIFE INSURANCE	26,439
EMPLOYEE EXPENSE	32,634
TOTAL (agree to Schedule V, line 22, col.8)	$ 894,331

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Capital One	885
Du Page County Health	850
Village of Bloomingdale	476
Other Fees	1,340
Classified Ads	228
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,779

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	4,432
Seminar Expense	
Seminars	7,731
Education	372
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,535

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTI # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NSG & REHABILITATION CENTER # 0049759 Report Period Beginning: 1/1/10 Ending: 12/31/10

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? **NO**
If YES, give association name and amount. **N/A**

(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. $ **58,949** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **141,803**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(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? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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? **NO**
Firm Name: **N/A**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.