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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0049759

Facility Name: West Suburban Nsg & Rehab Ctr

Address: 311 Edgewater Dr (Number) Bloomingdale (City) 60108 (Zip Code)

County: DuPage

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: Alan Sorscher **Telephone Number:** (708) 449-1900
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 1/1/12 to 12/31/12 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) Alan Sorscher
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	94,794	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	94,794	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	57,024	3,573	8,020	68,617	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,024	3,573	8,020	68,617	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.39%

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 6,841

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: 12/31/12 Fiscal Year: 12/31/12

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

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	343,839	42,105	15,000	400,944		400,944	(4,623)	396,321			1
2	Food Purchase		329,536		329,536		329,536		329,536			2
3	Housekeeping	278,236	69,392		347,628		347,628		347,628			3
4	Laundry	50,518	39,887		90,405		90,405		90,405			4
5	Heat and Other Utilities			264,851	264,851		264,851	669	265,520			5
6	Maintenance	64,090	39,609	38,668	142,367		142,367	(3,640)	138,727			6
7	Other (specify):*											7
8	**TOTAL General Services**	736,683	520,529	318,519	1,575,731		1,575,731	(7,594)	1,568,137			8
	B. Health Care and Programs											
9	Medical Director			27,500	27,500		27,500		27,500			9
10	Nursing and Medical Records	4,292,991	599,937	34,010	4,926,938		4,926,938	16,071	4,943,009			10
10a	Therapy			763,788	763,788		763,788		763,788			10a
11	Activities	171,983	27,612		199,595		199,595		199,595			11
12	Social Services	96,347		317	96,664		96,664		96,664			12
13	CNA Training											13
14	Program Transportation			3,203	3,203		3,203		3,203			14
15	Other (specify):* **Pharmacy Consultant**			20,322	20,322		20,322		20,322			15
16	**TOTAL Health Care and Programs**	4,561,321	627,549	849,140	6,038,010		6,038,010	16,071	6,054,081			16
	C. General Administration											
17	Administrative	93,412			93,412		93,412		93,412			17
18	Directors Fees											18
19	Professional Services			294,458	294,458		294,458	(249,332)	45,126			19
20	Dues, Fees, Subscriptions & Promotions			16,828	16,828		16,828	550	17,378			20
21	Clerical & General Office Expenses	219,989	109,784	30,652	360,425		360,425	43,171	403,596			21
22	Employee Benefits & Payroll Taxes			1,082,730	1,082,730		1,082,730	72,953	1,155,683			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,239	6,239		6,239	274	6,513			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			134,130	134,130		134,130	82,101	216,231			26
27	Other (specify):*											27
28	**TOTAL General Administration**	313,401	109,784	1,565,037	1,988,222		1,988,222	(50,283)	1,937,939			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,611,405	1,257,862	2,732,696	9,601,963		9,601,963	(41,806)	9,560,157			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 West Suburban Nsg & Rehab Ctr #0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			47,894	47,894		47,894	314,753	362,647			30
31	Amortization of Pre-Op. & Org.			403	403		403	392,555	392,958			31
32	Interest			265,471	265,471		265,471	734,120	999,591			32
33	Real Estate Taxes							134,622	134,622			33
34	Rent-Facility & Grounds			2,243,212	2,243,212		2,243,212	(2,236,203)	7,009			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			3,954	3,954		3,954		3,954			36
37	TOTAL Ownership			2,560,934	2,560,934		2,560,934	(660,153)	1,900,781			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		391,797		391,797		391,797		391,797			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			802,359	802,359		802,359		802,359			42
43	Other (specify):* Bad Debt			825,000	825,000		825,000		825,000			43
44	TOTAL Special Cost Centers		391,797	1,627,359	2,019,156		2,019,156		2,019,156			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,611,405	1,649,659	6,920,989	14,182,053		14,182,053	(701,959)	13,480,094			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 West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	52,457	30		9
10	Interest and Other Investment Income	(1,024)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(21,865)	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	8,646	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 38,214		$	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)	(740,173)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (740,173)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (701,959)		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

STATE OF ILLINOIS **Page 5A**

West Suburban Nsg & Rehab Ctr

ID# **0049759**

Report Period Beginning: **1/1/12**

Ending: **12/31/12**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ 8,646	21	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				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**	8,646		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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	0	(4,623)	0	0	0	0	0	0	0	0	0	(4,623)	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	669	0	0	0	0	0	0	0	0	0	669	5
6	Maintenance	0	(3,640)	0	0	0	0	0	0	0	0	0	(3,640)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(7,594)	0	0	0	0	0	0	0	0	0	(7,594)	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	16,071	0	0	0	0	0	0	0	0	0	16,071	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	16,071	0	0	0	0	0	0	0	0	0	16,071	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	(268,888)	19,556	0	0	0	0	0	0	0	0	(249,332)	19
20	Fees, Subscriptions & Promotions	0	0	550	0	0	0	0	0	0	0	0	550	20
21	Clerical & General Office Expenses	(13,219)	56,308	82	0	0	0	0	0	0	0	0	43,171	21
22	Employee Benefits & Payroll Taxes	0	72,953	0	0	0	0	0	0	0	0	0	72,953	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	274	0	0	0	0	0	0	0	0	0	274	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	454	81,647	0	0	0	0	0	0	0	0	82,101	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,219)	(138,899)	101,835	0	0	0	0	0	0	0	0	(50,283)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,219)	(130,422)	101,835	0	0	0	0	0	0	0	0	(41,806)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number West Suburban Nsg & Rehab Ctr **#** 0049759 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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	52,457	172	262,124	0	0	0	0	0	0	0	0	314,753	30
31	Amortization of Pre-Op. & Org.	0	0	392,555	0	0	0	0	0	0	0	0	392,555	31
32	Interest	(1,024)	0	735,144	0	0	0	0	0	0	0	0	734,120	32
33	Real Estate Taxes	0	0	134,622	0	0	0	0	0	0	0	0	134,622	33
34	Rent-Facility & Grounds	0	7,009	(2,243,212)	0	0	0	0	0	0	0	0	(2,236,203)	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	51,433	7,181	(718,767)	0	0	0	0	0	0	0	0	(660,153)	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)	38,214	(123,241)	(616,932)	0	0	0	0	0	0	0	0	(701,959)	45

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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
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	$ 15,087	INFINITY HEALTHCARE MANAGEMENT		$ 10,464	$ (4,623)	1
2	V	6	Maintenance Wages	7,863	INFINITY HEALTHCARE MANAGEMENT		3,031	(4,832)	2
3	V	10	Nursing Wages	25,200	INFINITY HEALTHCARE MANAGEMENT		41,271	16,071	3
4	V	21	Office Wages		INFINITY HEALTHCARE MANAGEMENT		88,874	88,874	4
5	V	5	Utilities		INFINITY HEALTHCARE MANAGEMENT		669	669	5
6	V	6	Maintenance		INFINITY HEALTHCARE MANAGEMENT		1,192	1,192	6
7	V	19	Professional Services	270,000	INFINITY HEALTHCARE MANAGEMENT		1,112	(268,888)	7
8	V	21	Office Expense	37,659	INFINITY HEALTHCARE MANAGEMENT		5,093	(32,566)	8
9	V	22	Employee Benefit	5,517	INFINITY HEALTHCARE MANAGEMENT		78,470	72,953	9
10	V	24	Auto/Travel Expense		INFINITY HEALTHCARE MANAGEMENT		274	274	10
11	V	26	Insurance		INFINITY HEALTHCARE MANAGEMENT		454	454	11
12	V	34	Rent		INFINITY HEALTHCARE MANAGEMENT		7,009	7,009	12
13	V	30	Depreciation		INFINITY HEALTHCARE MANAGEMENT		172	172	13
14	Total			$ 361,326			$ 238,085	$ * (123,241)	14

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

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	19	Professional Fees	$	WEST SUBURBAN NURSING REALTY		$ 19,556	$ 19,556	15
16	V	20	Filing Fees		WEST SUBURBAN NURSING REALTY		550	550	16
17	V	21	Bank Service Charge		WEST SUBURBAN NURSING REALTY		82	82	17
18	V	26	Insurance		WEST SUBURBAN NURSING REALTY		81,647	81,647	18
19	V	30	Depreciation		WEST SUBURBAN NURSING REALTY		262,124	262,124	19
20	V	31	Amortization		WEST SUBURBAN NURSING REALTY		392,555	392,555	20
21	V	32	Mortgage Expense		WEST SUBURBAN NURSING REALTY		735,144	735,144	21
22	V	33	Property Tax Expense		WEST SUBURBAN NURSING REALTY		134,622	134,622	22
23	V	34	Rent	2,243,212	WEST SUBURBAN NURSING REALTY			(2,243,212)	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			$ 2,243,212			$ 1,626,280	$ * (616,932)	39

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

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 84,486	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.)		$ 156,718	2
3. Under or (over) accrual (line 2 minus line 1).		$ 72,232	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 62,390	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.		$ 134,622	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	146,655	8
	2008	153,409	9
	2009	158,242	10
	2010	137,088	11
	2011	156,718	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	7/1/09	$ 14,450,000	$ 13,911,114	6/30/2049	5.2500	$ 735,144	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Merit Bank		X	Working Capital	None		2,800,000	1,590,000	12/7/12	5.5000	82,764	6
7	Infinity Funding	X		Working Capital	Various	Various	Various	3,510,000	Various	Various	182,706	7
8												8
9	TOTAL Facility Related				$75,247.00		$ 17,250,000	$ 19,011,114			$ 1,000,614	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 17,250,000	$ 19,011,114			$ 1,000,614	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.)**

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME West Suburban Nsg & Rehab Ctr COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0049759

CONTACT PERSON REGARDING THIS REPORT Moishe Gubin

TELEPHONE (708) 449-1900 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(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	$ 156,717.96	$ 156,717.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 156,717.96	$ 156,717.96

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			2007	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	259		2007		$ 7,270,000	$ 186,410	39	$ 186,410	$	$ 963,118	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PTAC Unit			2007	2,145	214	5	429	215	2,145	9
10	Ceiling Tile, Floor Tile, and Wall Tile			2008	5,720	147	39	147		733	10
11	Ceramic Cove Base			2008	160	4	39	4		21	11
12	Ceiling Tile			2008	255	7	39	7		33	12
13	A/C Unit Roof Top			2008	4,440	114	39	114		569	13
14	Plumbing			2008	7,400	190	39	190		949	14
15	Mortar, Metal Trim, Drywall			2008	399	10	39	10		51	15
16	Mortar, Metal Trim, Drywall			2008	214	5	39	5		27	16
17	Mortar, Metal Trim, Drywall			2008	50	1	39	1		6	17
18	Remodel (1st Floor Shower Room)			2008	3,000	77	39	77		385	18
19	3 A/C Unit Roof Top			2008	2,426	62	39	62		311	19
20	Service Parts for Nurse Call Systems			2008	672	17	39	17		86	20
21	Standby Generator Replacement			2008	900	23	39	23		115	21
22	Roofing Work			2008	1,500	38	39	38		192	22
23	Roofing Work			2008	32,500	833	39	833		4,167	23
24	Generator - 1st Installment			2008	18,013	462	39	462		2,309	24
25	Permit for Generator Work			2008	409	10	39	10		52	25
26	Generator - 2nd Installment			2008	18,013	462	39	462		2,309	26
27	Service Call and Testing for New Generator			2008	697	18	39	18		89	27
28	Adjustment to g/l			2008	(5,700)	(146)	39	(146)		(731)	28
29	Air Conditioner			2009	644	17	39	17		66	29
30	New Carpet			2009	1,164	30	39	30		119	30
31	Dining Room Heater Unit			2009	7,970	204	39	204		817	31
32	New Roof			2009	29,150	747	39	747		2,990	32
33	New Roof			2009	2,130	55	39	55		218	33
34	New Concrete for Entrance			2009	4,760	122	39	122		488	34
35	Dining Room Heater Unit			2010	22,295	572	39	572		1,715	35
36	Shower Room Floor Tiles			2010	6,819	175	39	175		525	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 West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	Shower Room Wall Tiles	2010	$ 9,803	$ 251	39	$ 251	$	$ 754	37
38	Corridor Wall Coverings, Stationary Panels, Vinyl Tiles	2010	75,237	1,929	39	1,929		5,787	38
39	Shower Room Floor Tiles	2010	136	3	39	3		10	39
40	Carrier 4 Ton Unit w/ Curb Adapter & Other Misc. Materials	2010	6,004	154	39	154		462	40
41	Draft Inducer Motor Assembly	2010	594	15	39	15		46	41
42	Shower Remodel - Valves, Faucets, Drywall	2010	3,800	97	39	97		292	42
43	PVC Pipes, Couplings, & Other Materials	2010	663	17	39	17		51	43
44	Shower Room Supplies - Fittings, Corners, Valves	2010	506	13	39	13		39	44
45	Shower Room Remodeling	2010	3,600	92	39	92		277	45
46	Shower Room Remodeling - Facuets, Valves, Paint Prep	2010	3,800	97	39	97		292	46
47	Sink Installation	2010	250	6	39	6		19	47
48	Replacement Shower Faucet	2010	200	5	39	5		15	48
49	Replacement Bricks	2010	1,950	50	39	50		150	49
50	Sheet Metal & Brick Repairs	2010	950	24	39	24		73	50
51	Patch to Wall Flashings	2010	350	9	39	9		27	51
52	Patch to Wall Flashings, Resealed Eams on Granulated Roof	2010	850	22	39	22		65	52
53	Concrete Sidewalk Repairs	2010	6,850	176	39	176		527	53
54	Parking Lot Lease Dues	2010	12	0	39	0		1	54
55	Blacktop Removal/Resurfacing	2010	7,500	192	39	192		577	55
56	John Brewer - Blacktop Removal/Resurfacing	2010	4,140	106	39	106		318	56
57	John Brewer - Blacktop Removal/Resurfacing	2010	3,200	82	39	82		246	57
58	Paint	2010	64	2	39	2		5	58
59	Surveying	2010	1,250	32	39	32		96	59
60	Ductwork Repairs in Ceiling	2010	3,964	102	39	102		305	60
61	Professional Engineering Services for a Parking Lot	2010	10,440	268	39	268		803	61
62	Elevator Valve Replacement	2011	8,250	212	39	212		423	62
63	Wet Pipe Fire Sprinkler System	2011	1,200	31	39	31		62	63
64	HUD Inspection	2011	845	22	39	22		43	64
65	Storm Water Management Application	2011	2,500	64	39	64		128	65
66	Planning, Parking Lot	2011	336	9	39	9		17	66
67	Planning, Parking Lot	2011	192	5	39	5		10	67
68	Planning, Parking Lot	2011	288	7	39	7		15	68
69	Roof Repairs	2011	3,500	90	39	90		179	69
70	TOTAL (lines 4 thru 69)		$ 7,601,369	$ 195,066		$ 195,281	$ 215	$ 995,994	70

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

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,601,369	$ 195,066		$ 195,281	$ 215	$ 995,994	1
2	Replace Sinks & Valves	9/10/2011	2,420	62	39	62		124	2
3	New Automatic Door Motor	3/24/2011	1,457	37	39	37		75	3
4	Parking Lot, Design/Development	8/24/2011	6,900	177	39	177		354	4
5	Elevator Shaft Sprinkler Heads	12/28/2011	3,855	99	39	99		198	5
6	Repair Electric Work, Permit	1/23/2011	550	14	39	14		28	6
7	Exhaust Fan/ Fire Alarm	4/5/2011	730	19	39	19		37	7
8	Repair Electric Work, Permit	9/17/2011	550	14	39	14		28	8
9	Steel Doors/Door Rims/ Door Lites	5/31/2011	1,269	33	39	33		65	9
10	Lighting Retrofit	4/28/2011	11,033	283	39	283		566	10
11	Door Trim	5/26/2011	1,089	28	39	28		56	11
12	Flooring, Dialysis Hallway & Storage	7/14/2011	1,900	49	39	49		97	12
13	Cooridor Doors	9/13/2011	2,126	55	39	55		109	13
14	Windows	10/23/2011	5,800	149	39	149		297	14
15	Windows & Frames	10/23/2011	7,991	205	39	205		410	15
16	100 gallon tank Water Heater	6/15/2012	4,533	116	39	68	(48)	116	16
17	Replaced compressor	9/11/2012	2,347	60	39	20	(40)	60	17
18	Rebuild metal framing over plumbing	10/15/2012	2,865	73	39	18	(55)	73	18
19	Infinity Healthcare	11/1/2012	11,323	290	39	48	(242)	290	19
20	Infinity Healthcare	12/1/2012	40,000	1,026	39	85	(941)	1,026	20
21	Infinity Healthcare	12/14/2012	54,323	1,393	39	116	(1,277)	1,393	21
22	Renovate patient treatment floor	9/24/2012	14,811	380	39	127	(253)	380	22
23	Install shunt trip	3/5/2012	2,600	67	39	56	(11)	67	23
24	Replace elevator disconnect	1/13/2012	2,880	74	39	74	0	74	24
25	Renovate nurses stations, corridors, therapy room, elevators	1/12/2012	410,486	10,525	39	10,525	(0)	10,525	25
26	Eidco Corporation	7/23/2012	2,880	74	39	37	(37)	74	26
27	Eidco Corporation	12/14/2012	(158,123)	(4,054)	39	(338)	3,716	(4,055)	27
28	Emergency electrical system	9/20/2012	2,448	63	39	21	(42)	63	28
29	Furnish (2) 54" x 7" printed and laminated lexanfaces	5/14/2012	1,290	33	39	22	(11)	33	29
30	Finish 2 nursing stations	11/5/2012	19,800	508	39	85	(423)	508	30
31	2 fluorescent fixtures	11/15/2012	760	19	39	3	(16)	19	31
32	custom cabinetry payout	12/17/2012	30,500	782	39	65	(717)	782	32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,094,761	$ 207,717		$ 207,535	$ (182)	$ 1,009,868	34

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

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 770,671	$ 96,155	$ 148,746	$ 52,591	5	$ 621,407	71
72	Current Year Purchases	61,457	6,146	6,393	247	5	6,146	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 832,128	$ 102,301	$ 155,139	$ 52,838		$ 627,553	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				$	$	$	$		$	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)	$ 9,326,889	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 310,018	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 362,674	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 52,656	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,637,421	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 & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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. 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.	/2013	$
13.	/2014	$
14.	/2015	$

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.

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 260,984	$		$ 260,984	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			108,411			108,411	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			394,393			394,393	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				378,404		378,404	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-2								12
13	Other (specify): RADIOLOGY/LAB						13,393		13,393	13
14	TOTAL			$		$ 763,788	$ 391,797		$ 1,155,585	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 West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$ (50,046)	$ 109,673	1
2	Cash-Patient Deposits	(11,423)	(11,423)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,796,409	4,796,409	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	523,101	523,101	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)**	$ 5,258,041	$ 5,417,760	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	824,759	824,759	15
16	Equipment, at Historical Cost	302,130	832,130	16
17	Accumulated Depreciation (book methods)	(257,876)	(1,637,421)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,048	5,894,364	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,149)	(2,021,867)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 872,912	$ 11,561,965	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,130,953	$ 16,979,725	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,661,686	$ 1,661,186	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	545,370	545,370	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	Working Capital - Related Party	3,510,000	3,510,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,717,056	$ 5,754,607	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,590,000	1,590,000	39
40	Mortgage Payable		13,911,114	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	$ 15,501,114	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,307,056	$ 21,255,721	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,176,103)	$ (4,275,996)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,130,953	$ 16,979,725	48

***(See instructions.)**

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 210,525	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 210,525	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,040,007)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock	(346,621)	9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,386,628)	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)**	$ (1,176,103)	24	*

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

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 12,131,821	1
2	Discounts and Allowances for all Levels	901,746	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,033,567	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	116,101	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 116,101	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		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		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,024	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,024	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	(8,646)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (8,646)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,142,046	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,575,731	31
32	Health Care	6,038,010	32
33	General Administration	1,988,222	33
	B. Capital Expense		
34	Ownership	2,560,934	34
	C. Ancillary Expense		
35	Special Cost Centers	1,216,797	35
36	Provider Participation Fee	802,359	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,182,053	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,040,007)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,040,007)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,617,722	44
45	Private Pay - Net Inpatient Revenue	734,536	45
46	Medicare - Net Inpatient Revenue	3,195,396	46
47	Other-(specify) Commercial Ins.	485,913	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,033,567	49

* **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.**

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

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	1,984	2,080	$ 131,125	$ 63.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	39,658	43,945	1,556,085	35.41	3
4	Licensed Practical Nurses	31,030	33,938	916,685	27.01	4
5	CNAs & Orderlies	114,888	125,962	1,613,267	12.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,925	8,865	171,983	19.40	9
10	Activity Assistants					10
11	Social Service Workers	3,992	4,280	96,347	22.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,752	30,351	343,839	11.33	15
16	Dishwashers					16
17	Maintenance Workers	3,882	4,284	64,090	14.96	17
18	Housekeepers	25,402	28,323	278,236	9.82	18
19	Laundry	5,203	5,808	50,518	8.70	19
20	Administrator	1,936	2,072	93,412	45.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,360	11,182	219,989	19.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,528	3,984	75,829	19.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	277,540	305,074	$ 5,611,405 *	$ 18.39	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	429	$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	680	34,010	10-3	38
39	Pharmacist Consultant	406	20,322	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9	317	12-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,524	$ 69,649		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 & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lynnette Torres	Admin		$ 13,718
Christofer Correll	Admin		79,694
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,412

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
Infinity Healthcare	Professional	$ 270,000
Capital One	Legal	12,883
First Merit	Legal	1,500
Bradley Assocaites	Accounting	7,575
Johnson, Goldberg & Brown	Accounting	2,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 294,458

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 361,993
Unemployment Compensation Insurance	78,956
FICA Taxes	425,040
Employee Health Insurance	133,481
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	540
Pension	34,298
Employee Expense	121,375
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,155,683

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	
Village of Bloomingdale	940
Dupage Co Health	850
Other license Dues	2,625
Illinois Council	12,963
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,378

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	1,197
Mileage	4,427
Seminar Expense	
Education	889
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,513

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number West Suburban Nsg & Rehab Ctr # 0049759 Report Period Beginning: 1/1/12 Ending: 12/31/12

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. $ **73,611** 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. $ **802,359**
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. $ **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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.