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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0049759

Facility Name: West Suburban Nsg & Reh Ctr

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: Alan Sorscher **Telephone Number:** 708-449-14900
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 1/1/14 to 12/31/14 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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	52,481	3,561	11,362	67,404	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,481	3,561	11,362	67,404	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.30%

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 [ ] Date 11/1/07 NO [X]

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 9,584

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	357,841	30,212	10,765	398,818		398,818	1,324	400,142			1
2	Food Purchase		331,686		331,686		331,686		331,686			2
3	Housekeeping	263,405	50,049		313,454		313,454		313,454			3
4	Laundry	68,923	35,237		104,160		104,160		104,160			4
5	Heat and Other Utilities			329,095	329,095		329,095	999	330,094			5
6	Maintenance	64,640	46,024	73,685	184,349		184,349	2,187	186,536			6
7	Other (specify):*											7
8	**TOTAL General Services**	754,809	493,208	413,545	1,661,562		1,661,562	4,510	1,666,072			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	4,286,122	426,136	18,203	4,730,461		4,730,461	47,292	4,777,753			10
10a	Therapy			1,313,238	1,313,238		1,313,238		1,313,238			10a
11	Activities	208,803	32,576		241,379		241,379		241,379			11
12	Social Services	99,620		1,476	101,096		101,096		101,096			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* **Pharmacy Consultant**			18,243	18,243		18,243		18,243			15
16	**TOTAL Health Care and Programs**	4,594,545	458,712	1,381,160	6,434,417		6,434,417	47,292	6,481,709			16
	C. General Administration											
17	Administrative	118,469			118,469		118,469		118,469			17
18	Directors Fees											18
19	Professional Services			324,551	324,551		324,551	(279,853)	44,698			19
20	Dues, Fees, Subscriptions & Promotions			27,099	27,099		27,099		27,099			20
21	Clerical & General Office Expenses	268,945	131,105	14,555	414,605		414,605	122,975	537,580			21
22	Employee Benefits & Payroll Taxes			907,917	907,917		907,917	31,365	939,282			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,876	13,876		13,876	383	14,259			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			173,441	173,441		173,441	997	174,438			26
27	Other (specify):*											27
28	**TOTAL General Administration**	387,414	131,105	1,461,439	1,979,958		1,979,958	(124,133)	1,855,825			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,736,768	1,083,025	3,256,144	10,075,937		10,075,937	(72,331)	10,003,606			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 & Reh Ctr #0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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			298,726	298,726		298,726	91,972	390,698			30
31	Amortization of Pre-Op. & Org.			392,958	392,958		392,958		392,958			31
32	Interest			948,196	948,196		948,196	(451)	947,745			32
33	Real Estate Taxes			169,522	169,522		169,522		169,522			33
34	Rent-Facility & Grounds			1,961,604	1,961,604		1,961,604	(1,945,927)	15,677			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			3,771,006	3,771,006		3,771,006	(1,854,406)	1,916,600			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		395,945		395,945		395,945		395,945			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			492,957	492,957		492,957		492,957			42
43	Other (specify):* Bad Debt			701,572	701,572		701,572	(701,572)				43
44	TOTAL Special Cost Centers		395,945	1,194,529	1,590,474		1,590,474	(701,572)	888,902			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,736,768	1,478,970	8,221,679	15,437,417		15,437,417	(2,628,309)	12,809,108			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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	91,972	30		9
10	Interest and Other Investment Income	(451)	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	(701,572)	43		24
25	Fund Raising, Advertising and Promotional	(20,597)	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 various	(1,969,916)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,600,564)		$	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)	(27,745)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (27,745)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,628,309)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

West Suburban Nsg & Reh Ctr

ID# 0049759

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (8,312)	21	1
2	Rent	(1,961,604)	34	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
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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**	(1,969,916)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	1,324	0	0	0	0	0	0	0	0	0	1,324	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	999	0	0	0	0	0	0	0	0	0	999	5
6	Maintenance	0	2,187	0	0	0	0	0	0	0	0	0	2,187	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	4,510	0	0	0	0	0	0	0	0	0	4,510	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	47,292	0	0	0	0	0	0	0	0	0	47,292	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	47,292	0	0	0	0	0	0	0	0	0	47,292	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	(279,853)	0	0	0	0	0	0	0	0	0	(279,853)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(28,909)	151,884	0	0	0	0	0	0	0	0	0	122,975	21
22	Employee Benefits & Payroll Taxes	0	31,365	0	0	0	0	0	0	0	0	0	31,365	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	383	0	0	0	0	0	0	0	0	0	383	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	997	0	0	0	0	0	0	0	0	0	997	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(28,909)	(95,224)	0	0	0	0	0	0	0	0	0	(124,133)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,909)	(43,422)	0	0	0	0	0	0	0	0	0	(72,331)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number West Suburban Nsg & Reh Ctr **#** 0049759 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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	91,972	0	0	0	0	0	0	0	0	0	0	91,972	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(451)	0	0	0	0	0	0	0	0	0	0	(451)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,961,604)	15,677	0	0	0	0	0	0	0	0	0	(1,945,927)	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	(1,870,083)	15,677	0	0	0	0	0	0	0	0	0	(1,854,406)	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):*	(701,572)	0	0	0	0	0	0	0	0	0	0	(701,572)	43
44	TOTAL Special Cost Centers	(701,572)	0	0	0	0	0	0	0	0	0	0	(701,572)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,600,564)	(27,745)	0	0	0	0	0	0	0	0	0	(2,628,309)	45

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	Mgmt 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	$ 10,765	Infinity Healthcare Management of Illinois		$ 12,089	$ 1,324	1
2	V	6	Maintenance Wages		Infinity Healthcare Management of Illinois		2,187	2,187	2
3	V	10	Nursing Wages	9,503	Infinity Healthcare Management of Illinois		56,795	47,292	3
4	V	21	Office wages		Infinity Healthcare Management of Illinois		198,571	198,571	4
5	V	5	Utilities		Infinity Healthcare Management of Illinois		999	999	5
6	V	2	Food		Infinity Healthcare Management of Illinois				6
7	V	19	Professional Services	286,178	Infinity Healthcare Management of Illinois		6,325	(279,853)	7
8	V	21	Office Expense	46,687	Infinity Healthcare Management of Illinois			(46,687)	8
9	V	22	Employee Benefit	1,954	Infinity Healthcare Management of Illinois		33,319	31,365	9
10	V	24	Aoto/Travel Expense	317	Infinity Healthcare Management of Illinois		700	383	10
11	V	26	Insurance		Infinity Healthcare Management of Illinois		997	997	11
12	V	34	Rent		Infinity Healthcare Management of Illinois		15,677	15,677	12
13	V	32	Interest		Infinity Healthcare Management of Illinois				13
14	Total			$ 355,404			$ 327,659	$ * (27,745)	14

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

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	HUD loan		x	mortgage	$72,126.00	11/30/2013	$ 14,450,000	$ 14,222,915	7/1/44	3.7080	$ 616,756	1
2												2
3												3
4												4
5												5
	Working Capital											
6	capital one		x	working capital	none	08/31/2014	26,000,000	339,141	08/31/2018	2.9590	40,226	6
7	infinity funding	x		working capital	none	various	various	2,956,000	various	various	291,214	7
8												8
9	TOTAL Facility Related				$72,126.00		$ 40,450,000	$ 17,518,056			$ 948,196	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 40,450,000	$ 17,518,056			$ 948,196	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.)**

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 95,374	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.)		$ 174,829	2
3. Under or (over) accrual (line 2 minus line 1).		$ 79,455	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 90,067	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.		$ 169,522	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	158,242	8
	2010	137,088	9
	2011	156,718	10
	2012	162,472	11
	2013	174,829	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME West Suburban Nsg & Reh Ctr COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0049759

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE 708-449-1900 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-23-124-022	Long Term Property	$ 174,828.84	$ 174,828.84
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 174,828.84	$ 174,828.84

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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: _____
(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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$	$ 1,335,938	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PTAC Unit			2007	2,145		5			2,145	9
10	Ceiling Tile, Floor Tile, and Wall Tile			2008	5,720	147	39	147		1,027	10
11	Ceramic Cove Base			2008	160	4	39	4		29	11
12	Ceiling Tile			2008	255	7	39	7		46	12
13	A/C Unit Roof Top			2008	4,440	114	39	114		797	13
14	Plumbing			2008	7,400	190	39	190		1,328	14
15	Mortar, Metal Trim, Drywall			2008	399	10	39	10		72	15
16	Mortar, Metal Trim, Drywall			2008	214	5	39	5		38	16
17	Mortar, Metal Trim, Drywall			2008	50	1	39	1		9	17
18	Remodel (1st Floor Shower Room)			2008	3,000	77	39	77		538	18
19	3 A/C Unit Roof Top			2008	2,426	62	39	62		435	19
20	Service Parts for Nurse Call Systems			2008	672	17	39	17		121	20
21	Standby Generator Replacement			2008	900	23	39	23		162	21
22	Roofing Work			2008	1,500	38	39	38		269	22
23	Roofing Work			2008	32,500	834	39	833	(1)	5,833	23
24	Generator - 1st Installment			2008	18,013	462	39	462		3,233	24
25	Permit for Generator Work			2008	409	10	39	10		73	25
26	Generator - 2nd Installment			2008	18,013	462	39	462		3,233	26
27	Service Call and Testing for New Generator			2008	697	18	39	18		125	27
28	Adjustment to g/l			2008	(5,700)	(146)	39	(146)		(1,023)	28
29	Air Conditioner			2009	644	17	39	17		99	29
30	New Carpet			2009	1,164	30	39	30		179	30
31	Dining Room Heater Unit			2009	7,970	204	39	204		1,226	31
32	New Roof			2009	29,150	748	39	747	(1)	4,485	32
33	New Roof			2009	2,130	55	39	55		328	33
34	New Concrete for Entrance			2009	4,760	122	39	122		732	34
35	Dining Room Heater Unit			2010	22,295	572	39	572		2,858	35
36				2010	6,819	175	39	175		874	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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$	$ 1,257	37
38	Corridor Wall Coverings, Stationary Panels, Vinyl Tiles	2010	75,237	1,930	39	1,929	(1)	9,646	38
39	Shower Room Floor Tiles	2010	136	3	39	3		17	39
40	Carrier 4 Ton Unit w/ Curb Adapter & Other Misc. Materials	2010	6,004	154	39	154		770	40
41	Draft Inducer Motor Assembly	2010	594	15	39	15		76	41
42	Shower Remodel - Valves, Faucets, Drywall	2010	3,800	97	39	97		487	42
43	PVC Pipes, Couplings, & Other Materials	2010	663	17	39	17		85	43
44	Shower Room Supplies - Fittings, Corners, Valves	2010	506	13	39	13		65	44
45	Shower Room Remodeling	2010	3,600	92	39	92		462	45
46	Shower Room Remodeling - Facuets, Valves, Paint Prep	2010	3,800	97	39	97		487	46
47	Sink Installation	2010	250	6	39	6		32	47
48	Replacement Shower Faucet	2010	200	5	39	5		26	48
49	Replacement Bricks	2010	1,950	50	39	50		250	49
50	Sheet Metal & Brick Repairs	2010	950	24	39	24		122	50
51	Patch to Wall Flashings	2010	350	9	39	9		45	51
52	Patch to Wall Flashings, Resealed Eams on Granulated Roof	2010	850	22	39	22		109	52
53	Concrete Sidewalk Repairs	2010	6,850	176	39	176		878	53
54	Parking Lot Lease Dues	2010	12		39			2	54
55	Blacktop Removal/Resurfacing	2010	7,500	192	39	192		962	55
56	John Brewer - Blacktop Removal/Resurfacing	2010	4,140	106	39	106		531	56
57	John Brewer - Blacktop Removal/Resurfacing	2010	3,200	82	39	82		410	57
58	Paint	2010	64	2	39	2		8	58
59	Surveying	2010	1,250	32	39	32		160	59
60	Ductwork Repairs in Ceiling	2010	3,964	102	39	102		508	60
61	Professional Engineering Services for a Parking Lot	2010	10,440	268	39	268		1,338	61
62	Elevator Valve Replacement	2011	8,250	212	39	212		846	62
63	Wet Pipe Fire Sprinkler System	2011	1,200	31	39	31		123	63
64	HUD Inspection	2011	845	22	39	22		87	64
65	Storm Water Management Application	2011	2,500	64	39	64		256	65
66	Planning, Parking Lot	2011	336	9	39	9		34	66
67	Planning, Parking Lot	2011	192	5	39	5		20	67
68	Planning, Parking Lot	2011	288	7	39	7		30	68
69	Roof Repairs	2011	3,500	89	39	90	1	359	69
70	TOTAL (lines 4 thru 69)		$ 7,601,369	$ 194,852		$ 194,850	$ (2)	$ 1,385,697	70

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

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 194,852		$ 194,850	$ (2)	$ 1,385,697	1
2	Replace Sinks & Valves	9/10/2011	2,420	62	39	62		248	2
3	New Automatic Door Motor	3/24/2011	1,457	37	39	37		149	3
4	Parking Lot, Design/Development	8/24/2011	6,900	177	39	177		708	4
5	Elevator Shaft Sprinkler Heads	12/28/2011	3,855	99	39	99		395	5
6	Repair Electric Work, Permit	1/23/2011	550	14	39	14		56	6
7	Exhaust Fan/ Fire Alarm	4/5/2011	730	19	39	19		75	7
8	Repair Electric Work, Permit	9/17/2011	550	14	39	14		56	8
9	Steel Doors/Door Rims/ Door Lites	5/31/2011	1,269	33	39	33		130	9
10	Lighting Retrofit on all floors/nurses stations/offices	4/28/2011	11,033	282	39	283	1	1,132	10
11	Door Trim	5/26/2011	1,089	28	39	28		112	11
12	Flooring, Dialysis Hallway & Storage	7/14/2011	1,900	49	39	49		195	12
13	Cooridor Doors	9/13/2011	2,126	55	39	55		218	13
14	Windows on 1st floor atrium	10/23/2011	5,800	149	39	149		595	14
15	Windows & Frames on 1st floor atrium	10/23/2011	7,991	204	39	205	1	820	15
16	100 gallon tank Water Heater	6/15/2012	4,533	116	39	116		349	16
17	Replaced compressor	9/11/2012	2,347	60	39	60		181	17
18	Rebuild metal framing over plumbing	10/15/2012	2,865	73	39	73		220	18
19	New floor & walls in Alzheimers Unit	11/1/2012	11,323	290	39	290		871	19
20	New floors & walls on 1st & 2nd floor nurses stations	12/1/2012	40,000	1,026	39	1,026		3,077	20
21	New floors, walls & borders in Alzheimers Unit/nurses station	12/14/2012	54,323	1,393	39	1,393		4,179	21
22	Renovate patient treatment floor in Dialysis unit	9/24/2012	14,811	380	39	380		1,139	22
23	Install shunt trip	3/5/2012	2,600	67	39	67		200	23
24	Replace elevator disconnect	1/13/2012	2,880	74	39	74		222	24
25									25
26	Eidco Corporation	7/23/2012	2,880	74	39	74		222	26
27	Eidco Corporation	12/14/2012	(158,123)	(4,055)	39	(4,054)	1	(12,164)	27
28	Emergency electrical system	9/20/2012	2,448	63	39	63		188	28
29	Furnish (2) 54" x 7" printed and laminated lexanfaces	5/14/2012	1,290	33	39	33		99	29
30	Finish 2 nursing stations	11/5/2012	19,800	508	39	508		1,523	30
31	2 fluorescent fixtures	11/15/2012	760	19	39	19		58	31
32	custom cabinetry payout - Nurses station 2nd floor	12/17/2012	30,500	782	39	782		2,346	32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,684,275	$ 196,977		$ 196,978	$ 1	$ 1,393,296	34

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

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,684,275	$ 196,977		$ 196,978	$ 1	$ 1,393,296	1
2	New flooring, walls, paint, ceiling tiles, cove base & wall								2
3	coverings at 1st floor nurses stations and corridors,								3
4	2nd floor nurses stations and corridors, 2nd floor therapy room								4
5	and passenger elevators 1 & 2	1/12/2012	410,486	10,526	39	10,525	(1)	31,576	5
6									6
7	Elevator Lift	6/17/2013	1,123	29	39	14	(15)	58	7
8	Carpet / flooring day room	3/6/2013	2,890	74	39	62	(12)	148	8
9	sanding / painting - day room	3/1/2013	1,932	50	39	41	(9)	99	9
10	HVAC carrier system	11/18/2013	8,698	223	39	19	(204)	446	10
11	relocate sprinkler heads - 1st & 2nd floors	1/14/2013	1,014	26	39	26	(0)	52	11
12	relocate sprinkler heads - 1st & 2nd floors	1/29/2013	1,074	28	39	25	(3)	55	12
13	relocate sprinkler heads - 1st & 2nd floors	11/30/2012	2,502	64	39	5	(59)	128	13
14	Light fixtures 1st floor	3/4/2013	440	11	39	9	(2)	23	14
15	Cabinets in PT room	4/11/2013	4,500	115	39	87	(28)	231	15
16	Cabinets in PT room	5/13/2013	6,240	160	39	107	(53)	320	16
17	Windows / Doors in PT room	1/11/2013	4,000	103	39	103	(0)	205	17
18	Carpet in PT room	2/5/2013	9,743	250	39	229	(21)	500	18
19	Crash bars - nurse station	2/1/2013	5,000	128	39	118	(10)	256	19
20	PT room 2nd fllor ceiling / door	2/7/2013	16,890	432	39	397	(35)	866	20
21	Windows trims	5/13/2013	2,500	64	39	43	(21)	128	21
22	2nd floor PT room windows	2/1/2013	16,000	410	39	376	(34)	820	22
23	PT room Paint windows/doors	3/17/2013	1,600	41	39	31	(10)	82	23
24	Door exit device	1/24/2013	2,610	67	39	61	(6)	134	24
25	Outlets - 2nd floor dining	5/13/2013	1,200	31	39	21	(10)	62	25
26	Celing grids / floor dining room	5/27/2013	1,122	29	39	17	(12)	58	26
27	Closets / dresers / call rooms	3/25/2013	9,000	231	39	173	(58)	462	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,194,838	$ 210,069		$ 209,466	$ (603)	$ 1,430,005	34

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

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 12C, Carried Forward		$ 8,194,838	$ 210,069		$ 209,466	$ (603)	$ 1,430,005	1
2	Kitchen door, hinge, fire exit installed	6/11/2014	5,513	141	39	141		141	2
3	Wall flashings, repair roof	5/30/2014	4,460	114	39	114		114	3
4	Furnish and install elevator door restrictors	8/4/2014	2,980	76	39	76		76	4
5	Furnish and install elevator operator, clutch, etc.	9/3/2014	5,800	149	39	149		149	5
6	Repair and paint walls throughout facility	9/7/2014	9,976	256	39	256		256	6
7	Install new safety close door	10/23/2014	2,233	57	39	57		57	7
8	Install 4 new heat detectors, rewired zone	10/24/2014	5,696	146	39	146		146	8
9	New beds for the facility	12/17/2014	41,000	1,051	39	1,051		1,051	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	TOTAL (lines 1 thru 33)		$ 8,272,496	$ 212,059		$ 211,456	$ (603)	$ 1,431,995	34

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

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 876,723	$ 67,180	$ 175,345	$ 108,165	5	$ 825,606	71
72	Current Year Purchases	19,487	19,487	3,897	(15,590)	5	19,487	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 896,210	$ 86,667	$ 179,242	$ 92,575		$ 845,093	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)	$ 9,568,706	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 298,726	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 390,698	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 91,972	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,277,088	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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$		$ 459,633	$		$ 459,633	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			131,324			131,324	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			722,281			722,281	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				398,734		398,734	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): RADIOLOGY/LAB/A	39-2					(2,789)		(2,789)	13
14	TOTAL			$		$ 1,313,238	$ 395,945		$ 1,709,183	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.

STATE OF ILLINOIS

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ (175,583)	$ 310,420	1
2	Cash-Patient Deposits	(11,493)	(11,493)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,684,061	3,684,061	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	298,134	298,134	6
7	Other Prepaid Expenses	389,338	389,805	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,184,457	$ 4,670,927	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	1,002,494	1,002,494	15
16	Equipment, at Historical Cost	366,212	896,212	16
17	Accumulated Depreciation (book methods)	(411,152)	(2,277,090)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	6,048	5,894,364	20
21	Restricted Funds	(2,960)	(2,807,788)	21
22	Other Long-Term Assets (specify):		273,047	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 960,642	$ 10,651,239	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,145,099	$ 15,322,166	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,321,495	$ 1,359,546	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,000,877	1,000,877	30
31	Accrued Taxes Payable (excluding real estate taxes)			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	2,956,000	2,956,000	36
37	working capital	339,141	339,141	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,617,513	$ 5,655,564	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		14,222,915	39
40	Mortgage Payable			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)**	$	$ 14,222,915	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,617,513	$ 19,878,479	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (472,414)	$ (4,556,313)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,145,099	$ 15,322,166	48

***(See instructions.)**

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,332,486)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,332,486)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,713,317	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	(350,902)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) **related party property co net income**	(502,343)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 860,072	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)**	$ (472,414)	24	*

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

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 14,652,630	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,652,630	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	526,351	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 526,351	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***	451	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 451	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	related party property co income	1,961,604	28
28a	misc and vend income	9,698	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,971,302	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,150,734	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,661,562	31
32	Health Care	6,434,417	32
33	General Administration	1,979,958	33
	B. Capital Expense		
34	Ownership	3,771,006	34
	C. Ancillary Expense		
35	Special Cost Centers	395,945	35
36	Provider Participation Fee	492,957	36
	D. Other Expenses (specify):		
37	bad debt	701,572	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,437,417	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,713,317	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,713,317	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,303,664	44
45	Private Pay - Net Inpatient Revenue	1,059,785	45
46	Medicare - Net Inpatient Revenue	4,908,290	46
47	Other-(specify) Commercial	380,891	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,652,630	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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	1,840	2,080	$ 135,284	$ 65.04	1
2	Assistant Director of Nursing	1,984	2,080	290,387	139.61	2
3	Registered Nurses	37,055	40,901	1,265,606	30.94	3
4	Licensed Practical Nurses	33,246	38,023	855,231	22.49	4
5	CNAs & Orderlies	102,857	114,025	1,654,078	14.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,849	2,337	73,768	31.57	9
10	Activity Assistants	8,566	9,271	135,035	14.57	10
11	Social Service Workers	3,976	4,320	99,620	23.06	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,120	51,954	24.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,896	26,828	305,887	11.40	15
16	Dishwashers					16
17	Maintenance Workers	3,440	3,713	64,640	17.41	17
18	Housekeepers	23,426	25,236	263,405	10.44	18
19	Laundry	6,698	7,377	68,923	9.34	19
20	Administrator	1,984	2,216	118,469	53.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,383	11,418	268,945	23.55	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	3,804	4,331	85,536	19.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	267,988	296,276	$ 5,736,768 *	$ 19.36	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	215	$ 10,765	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	364	18,203	10-3	38
39	Pharmacist Consultant	365	18,243	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	30	1,476	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	974	$ 48,687		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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christopher Correll	Administrator		$ 9,644
Juvenal Gonzalez	Administrator		108,825
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 118,469

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
Polsinelli	Legal fees	$ 113
Scalambrino & Arnoff	Legal fees	2,295
Bradley & Assocites	Acct fees	8,173
Johnson, Goldberg	Acct fees	2,500
MTS Consulting	Prof fees	1,318
Emdeon	Prof fees	4,449
Infinity Healthcare	Mgmt fees	294,076
Gauthier & Kimmerling	Acct fees	4,700
Lefkovitz & Associates	Legal fees	6,926
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 324,551

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 214,971
Unemployment Compensation Insurance	57,384
FICA Taxes	429,664
Employee Health Insurance	154,317
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
pension	33,009
uniforms	(272)
employee expense	50,209
TOTAL (agree to Schedule V, line 22, col.8)	$ 939,282

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

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	
illinois council	14,307
joint commission	3,315
village of bloomindale	150
sec of state	250
various	9,077
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,099

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
auto allowance	9,375
mileage	4,041
continuing education	424
Seminar Expense	
seminars	419
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,259

**See instructions.

Facility Name & ID Number West Suburban Nsg & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 & Reh Ctr # 0049759 Report Period Beginning: 1/1/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL**

(3) Did the nursing home make political contributions or payments to a political action organization? **N/A** 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. $ **70,312** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **492,957**
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? **NO**

(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? **0** 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. N/A
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 out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.