FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0049759

Facility Name: West Suburban Nsg & Reha Ctr

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

County: Du Page

Telephone Number: 708 449-1900 **Fax #** 708 449-1500

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar **Telephone Number:** 317 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 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) Flora Reznik
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) 317 237-5500 Fax # 317 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	61,170	1,556	6,442	69,168	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,170	1,556	6,442	69,168	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.97%

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 5,751

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	389,143		49,687	438,830		438,830	(2,272)	436,558			1
2	Food Purchase		334,585		334,585		334,585	717	335,302			2
3	Housekeeping	229,319	38,347		267,666		267,666	454	268,120			3
4	Laundry	111,652	30,244		141,896		141,896		141,896			4
5	Heat and Other Utilities			312,708	312,708		312,708	613	313,321			5
6	Maintenance	87,582	39,094	87,838	214,514		214,514	1,099	215,613			6
7	Other (specify):*											7
8	TOTAL General Services	817,696	442,270	450,233	1,710,199		1,710,199	611	1,710,810			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	4,545,558	354,799	46,175	4,946,532		4,946,532	(28,922)	4,917,610			10
10a	Therapy			1,562,854	1,562,854		1,562,854		1,562,854			10a
11	Activities	244,803	44,469		289,272		289,272	2,882	292,154			11
12	Social Services	97,936		4,370	102,306		102,306		102,306			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			20,367	20,367		20,367		20,367			15
16	TOTAL Health Care and Programs	4,888,297	399,268	1,663,766	6,951,331		6,951,331	(26,040)	6,925,291			16
	C. General Administration											
17	Administrative	140,426			140,426		140,426		140,426			17
18	Directors Fees											18
19	Professional Services			407,539	407,539		407,539	(172,680)	234,859			19
20	Dues, Fees, Subscriptions & Promotions			13,208	13,208		13,208	(236)	12,972			20
21	Clerical & General Office Expenses	227,804	95,982	95,553	419,339		419,339	116,251	535,590			21
22	Employee Benefits & Payroll Taxes			948,521	948,521		948,521	53,130	1,001,651			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,816	11,816		11,816	1,517	13,333			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			381,399	381,399		381,399	90,366	471,765			26
27	Other (specify):*											27
28	TOTAL General Administration	368,230	95,982	1,858,036	2,322,248		2,322,248	88,348	2,410,596			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,074,223	937,520	3,972,035	10,983,778		10,983,778	62,919	11,046,697			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 & Reha Ctr #0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			116,565	116,565		116,565	136,292	252,857			30
31	Amortization of Pre-Op. & Org.			403	403		403	392,555	392,958			31
32	Interest			94,994	94,994		94,994	574,732	669,726			32
33	Real Estate Taxes							171,878	171,878			33
34	Rent-Facility & Grounds			1,961,604	1,961,604		1,961,604	(1,955,346)	6,258			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,173,566	2,173,566		2,173,566	(679,889)	1,493,677			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,281	1,281		1,281		1,281			38
39	Ancillary Service Centers		332,953		332,953		332,953		332,953			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			521,816	521,816		521,816		521,816			42
43	Other (specify):*			667,566	667,566		667,566	(667,566)				43
44	**TOTAL Special Cost Centers**		332,953	1,190,663	1,523,616		1,523,616	(667,566)	856,050			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,074,223	1,270,473	7,336,264	14,680,960		14,680,960	(1,284,536)	13,396,424			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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(12,525)	30		9
10	Interest and Other Investment Income	(2,334)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(667,566)	43		24
25	Fund Raising, Advertising and Promotional	(18,297)	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	(1,821)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (702,582)		$	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)	(581,954)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (581,954)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,284,536)		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 & Reha Ctr

ID# 0049759

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (1,267)	21	1
2	PAC expenses	(554)	20	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**	(1,821)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(39)	(2,233)	0	0	0	0	0	0	0	0	0	(2,272)	1
2	Food Purchase	0	717	0	0	0	0	0	0	0	0	0	717	2
3	Housekeeping	0	454	0	0	0	0	0	0	0	0	0	454	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	613	0	0	0	0	0	0	0	0	0	613	5
6	Maintenance	0	1,099	0	0	0	0	0	0	0	0	0	1,099	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(39)	650	0	0	0	0	0	0	0	0	0	611	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	(28,922)	0	0	0	0	0	0	0	0	0	(28,922)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,882	0	0	0	0	0	0	0	0	0	2,882	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	(26,040)	0	0	0	0	0	0	0	0	0	(26,040)	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	(178,810)	6,130	0	0	0	0	0	0	0	0	(172,680)	19
20	Fees, Subscriptions & Promotions	(554)	318	0	0	0	0	0	0	0	0	0	(236)	20
21	Clerical & General Office Expenses	(19,564)	132,896	2,919	0	0	0	0	0	0	0	0	116,251	21
22	Employee Benefits & Payroll Taxes	0	53,130	0	0	0	0	0	0	0	0	0	53,130	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,517	0	0	0	0	0	0	0	0	0	1,517	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	375	89,991	0	0	0	0	0	0	0	0	90,366	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,118)	9,426	99,040	0	0	0	0	0	0	0	0	88,348	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,157)	(15,964)	99,040	0	0	0	0	0	0	0	0	62,919	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number West Suburban Nsg & Reha Ctr **#** 0049759 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	(12,525)	0	148,817	0	0	0	0	0	0	0	0	136,292	30
31	Amortization of Pre-Op. & Org.	0	0	392,555	0	0	0	0	0	0	0	0	392,555	31
32	Interest	(2,334)	0	577,066	0	0	0	0	0	0	0	0	574,732	32
33	Real Estate Taxes	0	0	171,878	0	0	0	0	0	0	0	0	171,878	33
34	Rent-Facility & Grounds	0	0	(1,955,346)	0	0	0	0	0	0	0	0	(1,955,346)	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**	(14,859)	0	(665,030)	0	0	0	0	0	0	0	0	(679,889)	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):*	(667,566)	0	0	0	0	0	0	0	0	0	0	(667,566)	43
44	**TOTAL Special Cost Centers**	(667,566)	0	0	0	0	0	0	0	0	0	0	(667,566)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(702,582)	(15,964)	(565,990)	0	0	0	0	0	0	0	0	(1,284,536)	45

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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
Michael Blisko	37.5%	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Mgmt. Co.
GELP	37.5%	Belhaven Nursing & Rehab Center	Chicago	West Suburban Nursing Realty		Realty Co.
Y&B Investments	20%	City View Multicare Center	Cicero			
A&F General Realty	5%	Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	$ 14,710	Infinity Healthcare Management		$ 12,477	$ (2,233)	1
2	V	2	Food Purchases		Infinity Healthcare Management		717	717	2
3	V	3	Housekeeping		Infinity Healthcare Management		454	454	3
4	V	5	Utilities		Infinity Healthcare Management		613	613	4
5	V	6	Maintenance		Infinity Healthcare Management		1,099	1,099	5
6	V	10	Nursing	46,196	Infinity Healthcare Management		17,274	(28,922)	6
7	V	11	Activities		Infinity Healthcare Management		2,882	2,882	7
8	V	19	Professional Fees	313,368	Infinity Healthcare Management		134,558	(178,810)	8
9	V	20	Dues, Fees, Subs, & Promotions		Infinity Healthcare Management		318	318	9
10	V	21	Office Expense	103,705	Infinity Healthcare Management		236,601	132,896	10
11	V	22	Employee Benefits		Infinity Healthcare Management		53,130	53,130	11
12	V	24	Travel & Seminar	79	Infinity Healthcare Management		1,596	1,517	12
13	V	26	Insurance		Infinity Healthcare Management		375	375	13
14	Total			$ 478,058			$ 462,094	$ * (15,964)	14

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

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	30	Depreciation	$	Infinity Healthcare Mangement		$ 266	$ 266	15
16	V	32	Interest		Infinity Healthcare Mangement		3,442	3,442	16
17	V	34	Rent		Infinity Healthcare Mangement		6,258	6,258	17
18	V								18
19	V	33	Property Tax		West Suburban Nursing Realty		171,878	171,878	19
20	V	26	Insurance		West Suburban Nursing Realty		89,991	89,991	20
21	V	31	Amortization		West Suburban Nursing Realty		392,555	392,555	21
22	V	19	Professional Services		West Suburban Nursing Realty		6,130	6,130	22
23	V	21	Office Expense		West Suburban Nursing Realty		2,919	2,919	23
24	V	30	Depreciation		West Suburban Nursing Realty		148,551	148,551	24
25	V	32	Interest		West Suburban Nursing Realty		573,624	573,624	25
26	V	34	Rent	1,961,604	West Suburban Nursing Realty			(1,961,604)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,961,604			$ 1,395,614	$ * (565,990)	39

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

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streator				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD Loan		X	mortgage	$72,126.00	11/16/13	$ 14,450,000	$ 13,757,562	7/1/44	3.7700	$ 553,940	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	working capital	none	8/31/14	26,000,000	2,025,806	8/31/18	2.9590	118,120	6
7												7
8												8
9	TOTAL Facility Related				$72,126.00		$ 40,450,000	$ 15,783,368			$ 672,060	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	$ 15,783,368			$ 672,060	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 77,304 Line # 26

*** 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 & Reha Ctr **#** 0049759 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 93,855	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.)		$ 171,536	2
3. Under or (over) accrual (line 2 minus line 1).		$ 77,681	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 94,197	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.		$ 171,878	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	156,718	8
2012	162,472	9
2013	174,829	10
2014	171,653	11
2015	171,536	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME West Suburban Nsg & Reha Ctr COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0049759

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

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

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-23-124-022	Long Term Property	$ 171,536.08	$ 171,536.08
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 171,536.08	$ 171,536.08

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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? [ ] 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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$	$ 1,708,758	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		1,321	10
11	Ceramic Cove Base			2008	160	4	39	4		37	11
12	Ceiling Tile			2008	255	7	39	7		60	12
13	A/C Unit Roof Top			2008	4,440	114	39	114		1,025	13
14	Plumbing			2008	7,400	190	39	190		1,708	14
15	Mortar, Metal Trim, Drywall			2008	399	10	39	10		92	15
16	Mortar, Metal Trim, Drywall			2008	214	5	39	5		48	16
17	Mortar, Metal Trim, Drywall			2008	50	1	39	1		11	17
18	Remodel (1st Floor Shower Room)			2008	3,000	77	39	77		692	18
19	3 A/C Unit Roof Top			2008	2,426	62	39	62		559	19
20	Service Parts for Nurse Call Systems			2008	672	17	39	17		155	20
21	Standby Generator Replacement			2008	900	23	39	23		208	21
22	Roofing Work			2008	1,500	38	39	38		345	22
23	Roofing Work			2008	32,500	833	39	833		7,499	23
24	Generator - 1st Installment			2008	18,013	462	39	462		4,157	24
25	Permit for Generator Work			2008	409	10	39	10		93	25
26	Generator - 2nd Installment			2008	18,013	462	39	462		4,157	26
27	Service Call and Testing for New Generator			2008	697	18	39	18		161	27
28	Adjustment to g/l			2008	(5,700)	(146)	39	(146)		(1,315)	28
29	Air Conditioner			2009	644	17	39	17		133	29
30	New Carpet			2009	1,164	30	39	30		239	30
31	Dining Room Heater Unit			2009	7,970	204	39	204		1,634	31
32	New Roof			2009	29,150	747	39	747		5,981	32
33	New Roof			2009	2,130	55	39	55		438	33
34	New Concrete for Entrance			2009	4,760	122	39	122		976	34
35	Dining Room Heater Unit			2010	22,295	572	39	572		4,002	35
36	Shower Room Flooring			2010	6,819	175	39	175		1,224	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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$	$ 1,759	37
38	Corridor Wall Coverings, Stationary Panels, Vinyl Tiles	2010	75,237	1,929	39	1,929		13,504	38
39	Shower Room Floor Tiles	2010	136	3	39	3		23	39
40	Carrier 4 Ton Unit w/ Curb Adapter & Other Misc. Materials	2010	6,004	154	39	154		1,078	40
41	Draft Inducer Motor Assembly	2010	594	15	39	15		106	41
42	Shower Remodel - Valves, Faucets, Drywall	2010	3,800	97	39	97		681	42
43	PVC Pipes, Couplings, & Other Materials	2010	663	17	39	17		119	43
44	Shower Room Supplies - Fittings, Corners, Valves	2010	506	13	39	13		91	44
45	Shower Room Remodeling	2010	3,600	92	39	92		646	45
46	Shower Room Remodeling - Facuets, Valves, Paint Prep	2010	3,800	97	39	97		681	46
47	Sink Installation	2010	250	6	39	6		44	47
48	Replacement Shower Faucet	2010	200	5	39	5		36	48
49	Replacement Bricks	2010	1,950	50	39	50		350	49
50	Sheet Metal & Brick Repairs	2010	950	24	39	24		170	50
51	Patch to Wall Flashings	2010	350	9	39	9		63	51
52	Patch to Wall Flashings, Resealed Eams on Granulated Roof	2010	850	22	39	22		153	52
53	Concrete Sidewalk Repairs	2010	6,850	176	39	176		1,230	53
54	Parking Lot Lease Dues	2010	12		39			2	54
55	Blacktop Removal/Resurfacing	2010	7,500	192	39	192		1,346	55
56	John Brewer - Blacktop Removal/Resurfacing	2010	4,140	106	39	106		743	56
57	John Brewer - Blacktop Removal/Resurfacing	2010	3,200	82	39	82		574	57
58	Paint	2010	64	2	39	2		12	58
59	Surveying	2010	1,250	32	39	32		224	59
60	Ductwork Repairs in Ceiling	2010	3,964	102	39	102		712	60
61	Professional Engineering Services for a Parking Lot	2010	10,440	268	39	268		1,874	61
62	Elevator Valve Replacement	2011	8,250	212	39	212		1,270	62
63	Wet Pipe Fire Sprinkler System	2011	1,200	31	39	31		185	63
64	HUD Inspection	2011	845	22	39	22		131	64
65	Storm Water Management Application	2011	2,500	64	39	64		384	65
66	Planning, Parking Lot	2011	336	9	39	9		52	66
67	Planning, Parking Lot	2011	192	5	39	5		30	67
68	Planning, Parking Lot	2011	288	7	39	7		44	68
69	Roof Repairs	2011	3,500	90	39	90		539	69
70	TOTAL (lines 4 thru 69)		$ 7,601,368	$ 194,850		$ 194,850	$	$ 1,775,399	70

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

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 7,601,368	$ 194,850		$ 194,850	$	$ 1,775,399	1
2	Replace Sinks & Valves	2011	2,420	62	39	62		372	2
3	New Automatic Door Motor	2011	1,457	37	39	37		223	3
4	Parking Lot, Design/Development	2011	6,900	177	39	177		1,062	4
5	Elevator Shaft Sprinkler Heads	2011	3,855	99	39	99		593	5
6	Repair Electric Work, Permit	2011	550	14	39	14		84	6
7	Exhaust Fan/ Fire Alarm Relay	2011	730	19	39	19		113	7
8	Repair Electric Work, Permit	2011	550	14	39	14		84	8
9	Steel Doors/ Door Rim/ Door Lite	2011	1,269	33	39	33		196	9
10	Lighting Retrofit on all floors/nurses stations/offices	2011	11,033	283	39	283		1,698	10
11	Door Trim	2011	1,089	28	39	28		168	11
12	Flooring, Dialysis Hallway & Storage	2011	1,900	49	39	49		293	12
13	Corridor Doors	2011	2,126	55	39	55		328	13
14	Windows on 1st floor atrium	2011	5,800	149	39	149		893	14
15	Windows and Frames on 1st floor atrium	2011	7,991	205	39	205		1,230	15
16	100 gallon tank Water Heater	2012	4,533	116	39	116		581	16
17	Replaced compressor	2012	2,347	60	39	60		301	17
18	Rebuild metal framing over plumbing	2012	2,865	73	39	73		366	18
19	New floor & walls in Alzheimers Unit	2012	11,323	290	39	290		1,451	19
20	New floors & walls on 1st & 2nd floor nurses stations	2012	40,000	1,026	39	1,026		5,129	20
21	New floors, walls & borders in Alzheimers Unit/nurses station	2012	54,323	1,393	39	1,393		6,965	21
22	Renovate patient treatment floor in Dialysis unit	2012	14,811	380	39	380		1,899	22
23	Install shunt trip	2012	2,600	67	39	67		334	23
24	Replace elevator disconnect	2012	2,880	74	39	74		370	24
25	Eidco Corporation	2012	2,880	74	39	74		370	25
26	Eidco Corporation	2012	(158,123)	(4,055)	39	(4,054)	1	(20,274)	26
27	Emergency electrical system	2012	2,448	63	39	63		314	27
28	Furnish (2) 54" x 7" printed and laminated lexanfaces	2012	1,290	33	39	33		165	28
29	Finish 2 nursing stations	2012	19,800	508	39	508		2,539	29
30	2 fluorescent fixtures	2012	760	19	39	19		96	30
31	custom cabinetry payout - Nurses station 2nd floor	2012	30,500	782	39	782		3,910	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,684,273	$ 196,977		$ 196,978	$ 1	$ 1,787,252	34

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

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 7,684,273	$ 196,977		$ 196,978	$ 1	$ 1,787,252	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								4
5	room and passenger elevators 1 & 2	2012	410,486	10,525	39	10,525		52,626	5
6	Elevator Lift	2013	1,123	29	39	29		116	6
7	Carpet / flooring day room	2013	2,890	74	39	74		296	7
8	sanding / painting - day room	2013	1,932	50	39	50		199	8
9	HVAC carrier system	2013	8,698	223	39	223		892	9
10	relocate sprinkler heads - 1st & 2nd floors	2013	1,014	26	39	26		104	10
11	relocate sprinkler heads - 1st & 2nd floors	2013	1,074	28	39	28		111	11
12	relocate sprinkler heads - 1st & 2nd floors	2013	2,502	64	39	64		256	12
13	Light fixtures 1st floor	2013	440	11	39	11		45	13
14	Cabinets in PT room	2013	4,500	115	39	115		461	14
15	Cabinets in PT room	2013	6,240	160	39	160		640	15
16	Windows / Doors in PT room	2013	4,000	103	39	103		411	16
17	Carpet in PT room	2013	9,743	250	39	250		1,000	17
18	Crash bars - nurse station	2013	5,000	128	39	128		512	18
19	PT room 2nd fllor ceiling / door	2013	16,890	433	39	433		1,732	19
20	Windows trims	2013	2,500	64	39	64		256	20
21	2nd floor PT room windows	2013	16,000	410	39	410		1,640	21
22	PT room Paint windows/doors	2013	1,600	41	39	41		164	22
23	Door exit device	2013	2,610	67	39	67		268	23
24	Outlets - 2nd floor dining	2013	1,200	31	39	31		124	24
25	Celing grids / floor dining room	2013	1,122	29	39	29		116	25
26	Closets / dresers / call rooms	2013	9,000	231	39	231		924	26
27	Kitchen door, hinge, fire exit installed	2014	5,513	141	39	141		423	27
28	Wall flashings, repair roof	2014	4,460	114	39	114		342	28
29	Furnish and install elevator door restrictors	2014	2,980	76	39	76		228	29
30	Furnish and install elevator operator, clutch, etc.	2014	5,800	149	39	149		447	30
31	Repair and paint walls throughout facility	2014	9,976	256	39	256		768	31
32	Install new safety close door	2014	2,233	57	39	57		171	32
33	Install 4 new heat detectors, rewired zone	2014	5,696	146	39	146		438	33
34	TOTAL (lines 1 thru 33)		$ 8,231,495	$ 211,008		$ 211,009	$ 1	$ 1,852,962	34

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

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 8,231,495	$ 211,008		$ 211,009	$ 1	$ 1,852,962	1
2	New beds for the facility	2014	41,000	1,051	39	1,051		3,153	2
3	Aluminum Car Sill	2015	2,674	69	39	69		138	3
4	Repair Grease Trap Chamber	2015	6,500	167	39	167		334	4
5	Replaced a Section of Roof Due to a Leak	2015	10,025	257	39	257		514	5
6	Replaced 7 downspouts	2015	4,900	126	39	126		252	6
7	Custom Overhead Light - Part 3	2015	4,374	112	39	112		224	7
8	Replaced 14 downspouts	2015	4,900	126	39	126		252	8
9	Replaced gutters	2015	5,900	151	39	151		302	9
10	Replaced a Section of Roof Due to a Leak	2015	10,025	257	39	257		514	10
11	Relocation of Existing Generator	2015	10,750	276	39	276		552	11
12	Closed Circuit TV System Part 1	2015	8,919	229	39	229		458	12
13	Karndean Vangough Flooring	2015	3,400	87	39	87		174	13
14	New Doors for Oxygen Room and Shower Room	2015	6,709	172	39	172		344	14
15	New Doors for Treatment Room, Oxygen Room, and Stairwell	2015	3,505	90	39	90		180	15
16	Closed Circuit TV System Part 2	2015	2,208	57	39	57		114	16
17	Repave Parking Lot	2016	51,044	1,309	39	1,309		1,309	17
18	Dining Room Chandeliers	2016	2,818	72	39	72		72	18
19	1st Floor Rewiring	2016	5,600	144	39	144		144	19
20	Cafeteria New Floor	2016	3,754	96	39	96		96	20
21	Cafeteria New Floor	2016	3,170	81	39	81		81	21
22	Pit Ladder	2016	3,900	100	39	100		100	22
23	Cafeteria New Floor	2016	1,332	34	39	34		34	23
24	Cafeteria New Floor	2016	3,755	96	39	96		96	24
25	Concrete & Sewer Work in Kitchen	2016	5,000	128	39	128		128	25
26	Disposal of 2015 asset	2016	(4,373)		39				26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,433,283	$ 216,295		$ 216,296	$ 1	$ 1,862,527	34

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

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 113,400	$ 17,273	$ 22,680	$ 5,407	5	$ 101,813	71
72	Current Year Purchases	69,407	69,407	13,881	(55,526)	5	69,407	72
73	Fully Depreciated Assets	843,639				5	843,639	73
74								74
75	TOTALS	$ 1,026,446	$ 86,680	$ 36,561	$ (50,119)		$ 1,014,859	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)	$ 9,859,729	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 302,975	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 252,857	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (50,118)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,877,386	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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$	8,027	$ 481,953	$	8,027	$ 481,953	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,472	132,506		2,472	132,506	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		10,351	678,395		10,351	678,395	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				314,928		314,928	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Radiology	39-2					10,925		10,925	12
13	Other (specify): Laboratory	39-2					7,100		7,100	13
14	TOTAL			$	20,850	$ 1,292,854	$ 332,953	20,850	$ 1,625,807	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 & Reha Ctr **#** 0049759 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ (47,711)	$ 563,951	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,355,163	3,355,163	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	313,570	313,570	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow Accounts		154,093	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,621,022	$ 4,386,777	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	1,163,283	1,163,283	15
16	Equipment, at Historical Cost	496,445	1,026,445	16
17	Accumulated Depreciation (book methods)	(638,627)	(2,877,385)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	52,352	5,940,668	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,766)	(3,593,704)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Reserves		213,906	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,069,687	$ 9,543,213	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,690,709	$ 13,929,990	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,875,952	$ 1,962,860	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,749	23,749	28
29	Short-Term Notes Payable		289,270	29
30	Accrued Salaries Payable	323,953	323,953	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,634	35,634	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		43,222	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	2,022,592	2,022,592	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,281,880	$ 4,701,280	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		13,468,292	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)**	$	$ 13,468,292	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,281,880	$ 18,169,572	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 408,829	$ (4,239,582)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,690,709	$ 13,929,990	48

***(See instructions.)**

Facility Name & ID Number West Suburban Nsg & Reha Ctr **#** 0049759 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (824,335)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (824,335)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,253,993	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	(20,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)	(829)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,233,164	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)**	$ 408,829	24 *

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

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 13,478,532	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,478,532	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,169,965	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,169,965	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	247,926	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,953	19
20	Radiology and X-Ray	12,300	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 283,179	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,010	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,010	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	1,267	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,267	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,934,953	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,710,199	31
32	Health Care	6,951,331	32
33	General Administration	2,322,248	33
	B. Capital Expense		
34	Ownership	2,173,566	34
	C. Ancillary Expense		
35	Special Cost Centers	332,953	35
36	Provider Participation Fee	521,816	36
	D. Other Expenses (specify):		
37	Medically Necessary Transportation	1,281	37
38	Bad Debt Expense	667,566	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,680,960	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,253,993	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,253,993	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,918,457	44
45	Private Pay - Net Inpatient Revenue	1,608,399	45
46	Medicare - Net Inpatient Revenue	344,117	46
47	Other-(specify)	607,559	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,478,532	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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,845	2,098	$ 145,582	$ 69.39	1
2	Assistant Director of Nursing	6,575	7,735	287,751	37.20	2
3	Registered Nurses	31,850	35,499	1,221,635	34.41	3
4	Licensed Practical Nurses	31,102	34,604	972,570	28.11	4
5	CNAs & Orderlies	99,244	112,885	1,717,089	15.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	14,030	15,355	244,803	15.94	9
10	Activity Assistants					10
11	Social Service Workers	3,490	4,077	97,936	24.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,224	28,215	389,143	13.79	15
16	Dishwashers					16
17	Maintenance Workers	3,782	3,993	87,582	21.93	17
18	Housekeepers	17,741	19,257	229,319	11.91	18
19	Laundry	9,954	10,650	111,652	10.48	19
20	Administrator	2,045	2,174	140,426	64.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,011	24,623	344,512	13.99	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	3,744	4,150	84,223	20.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	273,637	305,315	$ 6,074,223 *	$ 19.89	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	420	$ 14,710	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,319	46,175	10-3	38
39	Pharmacist Consultant	407	20,367	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	5,400	270,000	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	84	2,930	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	7,630	$ 354,182		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 & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Juvenal Gonzalez	Administrator		$ 140,426
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 140,426

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Bradley Associates	Accounting	$ 7,833
Johnson & Goldburg	Accounting	2,900
Capital One	Accounting	6,795
Scalambrino & Arnoff, LLP	Legal	37,380
Wilson Elser Moskowitz	Legal	1,502
DTI	Legal	49
MTS Consulting	Professional	4,353
Pinnacle Quality Insight	Professional	1,080
Infinity Healthcare	Professional/Mgmt	345,647
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 407,539

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ (86,856)
Unemployment Compensation Insurance	50,945
FICA Taxes	466,561
Employee Health Insurance	445,533
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	5,901
Pension Expense	90,397
Employee Expense	29,170
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,001,651

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	
Joint Commission	2,700
IHCA	8,248
Dupage County Health Dept	800
Bloomingdale Chamber of Commerce	375
Various	849
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,972

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	10,678
Auto allowance	1,433
Seminar Expense	
Education & Seminars	1,222
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,333

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number West Suburban Nsg & Reha Ctr # 0049759 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 8,248**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **92,945** 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. $ **521,816**
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) 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