

Facility Name & ID Number WEST SUBURBAN NURSING & REHABILITATION CENTER

0049759 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>259</u>	Skilled (SNF)	<u>259</u>	<u>94,535</u>	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	<u>259</u>	TOTALS	<u>259</u>	<u>94,535</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>52,081</u>	<u>4,878</u>	<u>10,070</u>	<u>67,029</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>52,081</u>	<u>4,878</u>	<u>10,070</u>	<u>67,029</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.90%

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)
NONVE

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 259 and days of care provided 9,042

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number **WEST SUBURBAN NURSING & REHABIL** # **0049759** Report Period Beginning: **1/1/09** Ending: **12/31/09**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	290,065	45,996	19,220	355,281		355,281	2,514	357,795		1
2	Food Purchase		345,542		345,542		345,542		345,542		2
3	Housekeeping	225,698	42,194		267,892		267,892		267,892		3
4	Laundry	107,383	18,053		125,436		125,436		125,436		4
5	Heat and Other Utilities			350,795	350,795		350,795	450	351,245		5
6	Maintenance	72,462	16,362	35,517	124,341		124,341		124,341		6
7	Other (specify):*										7
8	TOTAL General Services	695,608	468,147	405,532	1,569,287		1,569,287	2,964	1,572,251		8
	B. Health Care and Programs										
9	Medical Director			22,600	22,600		22,600		22,600		9
10	Nursing and Medical Records	4,549,895	575,413	38,411	5,163,719		5,163,719	15,233	5,178,952		10
10a	Therapy			1,021,686	1,021,686		1,021,686		1,021,686		10a
11	Activities	172,668	32,651		205,319		205,319		205,319		11
12	Social Services	79,167		1,582	80,749		80,749		80,749		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* PHARM. CONSULT.			4,207	4,207		4,207		4,207		15
16	TOTAL Health Care and Programs	4,801,730	608,064	1,088,486	6,498,280		6,498,280	15,233	6,513,513		16
	C. General Administration										
17	Administrative	107,957			107,957		107,957	(10,000)	97,957		17
18	Directors Fees										18
19	Professional Services			274,115	274,115		274,115	(252,755)	21,360		19
20	Dues, Fees, Subscriptions & Promotions			3,649	3,649		3,649	250	3,899		20
21	Clerical & General Office Expenses	215,004	65,401	40,146	320,551		320,551	71,415	391,966		21
22	Employee Benefits & Payroll Taxes			846,437	846,437		846,437	23,428	869,865		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,671	8,671		8,671	4,936	13,607		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			130,276	130,276		130,276	180,781	311,057		26
27	Other (specify):*										27
28	TOTAL General Administration	322,961	65,401	1,303,294	1,691,656		1,691,656	18,055	1,709,711		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,820,299	1,141,612	2,797,312	9,759,223		9,759,223	36,252	9,795,475		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			24,687	24,687		24,687	296,777	321,464			30
31	Amortization of Pre-Op. & Org.							392,555	392,555			31
32	Interest			96,853	96,853		96,853	1,031,221	1,128,074			32
33	Real Estate Taxes							143,056	143,056			33
34	Rent-Facility & Grounds			1,680,000	1,680,000		1,680,000	(1,679,138)	862			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,801,540	1,801,540		1,801,540	184,471	1,986,011			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		320,524		320,524		320,524		320,524			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,803	141,803		141,803		141,803			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		320,524	141,803	462,327		462,327		462,327			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,820,299	1,462,136	4,740,655	12,023,090		12,023,090	220,723	12,243,813			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	34,653	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(124)	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	(18,720)	21		18
19	Entertainment				19
20	Contributions	(6,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,799)	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	(11,562)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,552)		\$	30

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	2	
		Amount	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)	224,275	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 224,275		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 220,723		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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

WEST SUBURBAN NURSING & REHABILITATION CENTER

ID# 0049759

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	MISCELLANEOUS INCOME	\$ (9,786)	21	1
2	COMMUTING	(1,003)	24	2
3	INTEREST INCOME	(773)	32	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	(11,562)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WEST SUBURBAN NURSING & REHABILITATION CEN

0049759

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(124)	2,638	0	0	0	0	0	0	0	0	0	2,514	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	450	0	0	0	0	0	0	0	0	0	450	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(124)	3,088	0	0	0	0	0	0	0	0	0	2,964	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	15,233	0	0	0	0	0	0	0	0	0	15,233	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	15,233	0	0	0	0	0	0	0	0	0	15,233	16
	C. General Administration													
17	Administrative	0	(10,000)	0	0	0	0	0	0	0	0	0	(10,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(252,755)	0	0	0	0	0	0	0	0	0	(252,755)	19
20	Fees, Subscriptions & Promotions	0	0	250	0	0	0	0	0	0	0	0	250	20
21	Clerical & General Office Expenses	(36,305)	101,713	6,007	0	0	0	0	0	0	0	0	71,415	21
22	Employee Benefits & Payroll Taxes	0	23,428	0	0	0	0	0	0	0	0	0	23,428	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,003)	5,939	0	0	0	0	0	0	0	0	0	4,936	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	548	180,233	0	0	0	0	0	0	0	0	180,781	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(37,308)	(131,127)	186,490	0	18,055	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,432)	(112,806)	186,490	0	36,252	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WEST SUBURBAN NURSING & REHABILITATION CE# 0049759

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	34,653	0	262,124	0	0	0	0	0	0	0	0	296,777	30
31	Amortization of Pre-Op. & Org.	0	0	392,555	0	0	0	0	0	0	0	0	392,555	31
32	Interest	(773)	0	1,031,994	0	0	0	0	0	0	0	0	1,031,221	32
33	Real Estate Taxes	0	0	143,056	0	0	0	0	0	0	0	0	143,056	33
34	Rent-Facility & Grounds	0	(1,679,138)	0	0	0	0	0	0	0	0	0	(1,679,138)	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	33,880	(1,679,138)	1,829,729	0	184,471	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(3,552)	(1,791,944)	2,016,219	0	0	0	0	0	0	0	0	220,723	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHMENT #1						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1	DIETARY	\$ 12,950	NEW YORK BOYS MANAGEMENT		\$ 15,588	\$ 2,638	1
2	V	10	NURSING & MED RECORDS	22,000			37,233	15,233	2
3	V	17	CLERICAL & GEN. OFFICE	10,000				(10,000)	3
4	V	19	PROFESSIONAL SERVICES	257,036			4,281	(252,755)	4
5	V	21	CLERICAL & GEN. OFFICE	13,021			114,734	101,713	5
6	V	22	EMPLOYEE BENEFITS & TAXES	1,834			25,262	23,428	6
7	V	24	TRAVEL AND SEMINAR	413			6,352	5,939	7
8	V	5	UTILITIES				450	450	8
9	V	26	INSURANCE				548	548	9
10	V	34	RENT				862	862	10
11	V	34	RENT	1,680,000	WEST SUBURBAN REALY, LLC			(1,680,000)	11
12	V								12
13	V								13
14	Total		\$ 1,997,254				\$ 205,310	\$ * (1,791,944)	14

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	31 AMORTIZATION	\$			\$ 392,555	\$ 392,555
16	V	21 CLERICAL & ADMIN				6,007	6,007
17	V	30 DEPRECIATION				262,124	262,124
18	V	20 SUBSCRIPTIONS				250	250
19	V	26 LIAB INSURANCE				180,233	180,233
20	V	32 INTEREST				1,031,994	1,031,994
21	V	33 PROP. TAX				143,056	143,056
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 2,016,219	\$ * 2,016,219

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

ATTACHMENT #1

OWNERS

NAME	OWNERSHIP %
MICHAEL BLISKO	37.500%
MOISHE GUBIN	37.500%
A&F GENERAL REALTY	5.000%
Y&B INVESTMENTS	<u>20.000%</u>
	<u><u>100.000%</u></u>

OTHER RELATED BUSINESS ENTITIES

NAME	CITY	TYPE OF BUSINESS
NEW YORK BOYS MANAGEMENT	CROWN POINT, IN	MANAGEMENT CO.

NOTE: NEW YORK BOYS MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number WEST SUBURBAN NURSING & REHABI # 0049759 Report Period Beginning: 1/1/09 Ending: 12/31/09

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NURSING & REHABILITATION CE # 0049759 Report Period Beginning: 1/1/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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										
										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	HEARTLAND BANK		X	HUD LOAN	\$75,247.00	7/1/09	\$ 14,450,000	\$ 14,389,328	6/30/49	5.2500	\$ 833,049	1							
2	MIDWEST BANK		X	MORTGAGE	\$83,479.00	11/1/07	11,200,000			7.5000	139,500	2							
3	MEISELS		X	MORTGAGE	\$25,500.00	11/1/07	3,400,000			9.0000	59,444	3							
4												4							
5												5							
Working Capital																			
6	MIDWEST BANK		X	WORKING CAPITAL	NONE	4/1/08	2,000,000	1,900,000	6/7/10	5.5000	96,853	6							
7												7							
8												8							
9	TOTAL Facility Related				\$184,226.00		\$ 31,050,000	\$ 16,289,328			\$ 1,128,846	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 31,050,000	\$ 16,289,328			\$ 1,128,846	15							

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

1. Total Amount Incurred: 194,364 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 13,092 4. Dates Incurred: 2007

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column. Row 1: FACILITY, 2007, \$400,000, 1. Row 2: 2, 2. Row 3: TOTALS, \$400,000, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	259		2007		\$ 7,270,000	\$ 186,410	39	\$ 186,410	\$	\$ 403,888	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		PTAC Unit	2007		2,145	55	39	55		110	9
10		Ceiling Tile, Floor Tile, and Wall Tile	2008		5,720	147	39	147	0	269	10
11		Ceramic Cove Base	2008		160	4	39	4	(0)	7	11
12		Ceiling Tile	2008		255	7	39	7	0	12	12
13		A/C Unit Roof Top	2008		4,440	114	39	114	0	209	13
14		Plumbing	2008		7,400	190	39	190	0	285	14
15		Mortar, Metal Trim, Drywall	2008		399	10	39	10	(0)	19	15
16		Mortar, Metal Trim, Drywall	2008		214	5	39	5	(0)	10	16
17		Mortar, Metal Trim, Drywall	2008		50	1	39	1	(0)	2	17
18		Remodel (1st Floor Shower Room)	2008		3,000	77	39	77	0	141	18
19		3 A/C Unit Roof Top	2008		2,426	62	39	62	(0)	93	19
20		Service Parts for Nurse Call Systems	2008		672	17	39	17	(0)	33	20
21		Standby Generator Replacement	2008		900	23	39	23	(0)	42	21
22		Roofing Work	2008		1,500	38	39	38	(0)	51	22
23		Roofing Work	2008		32,500	833	39	833	(0)	902	23
24		Generator - 1st Installment	2008		18,013	462	39	462	0	654	24
25		Permit for Generator Work	2008		409	10	39	10	(0)	12	25
26		Generator - 2nd Installment	2008		18,013	462	39	462	0	539	26
27		Service Call and Testing for New Generator	2008		697	18	39	18	0	21	27
28		Adjustment to g/l	2008		(5,700)		39				28
29		Air Conditioner	2009		644	17	39	15	(2)	15	29
30		New Carpet	2009		1,164	30	39	7	(23)	7	30
31		Dining Room Heater Unit	2009		7,970	204	39	204	(0)	204	31
32		New Roof	2009		29,150	747	39	623	(124)	623	32
33		New Roof	2009		2,130	55	39	41	(14)	41	33
34		New Concrete for Entrance	2009		4,760	122	39	61	(61)	61	34
35							39				35
36											36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			7,409,031		190,121	189,896	(225)	408,250

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 648,381	\$ 93,818	\$ 129,676	\$ 35,858	5 YRS	\$ 217,922	71
72	Current Year Purchases	17,287	3,097	1,892	(1,205)	5 YRS	1,892	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 665,668	\$ 96,915	\$ 131,568	\$ 34,653		\$ 219,814	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	n/a			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,474,699	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 287,036	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 321,464	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 34,428	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 628,064	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10a-3	hrs					\$ 402,905							\$ 402,905	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs					92,749							92,749	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs					526,032							526,032	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										301,555			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): <u>Lab, X-Ray, Ambul.</u>	39-2											18,970			13
14	TOTAL							\$ 1,021,686					320,525		\$ 1,021,686	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NURSING & REHABILITATION CEN# 0049759 Report Period Beginning: 1/1/09 Ending: 12/31/09
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/09 (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	\$ 10,127	\$ 382,165	1
2	Cash-Patient Deposits	(468)	(468)	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,288,872	3,849,372	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	271,460	271,460	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,569,991	\$ 4,502,529	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	139,029	139,029	15
16	Equipment, at Historical Cost	135,669	665,669	16
17	Accumulated Depreciation (book methods)	(42,726)	(635,899)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,048	349,112	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(940)	(19,660)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>SPE Sec. Deposit</u>)		4,876,667	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 237,080	\$ 13,044,918	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,807,071	\$ 17,547,447	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,620,858	\$ 1,620,858	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	459,888	459,888	30
31	Accrued Taxes Payable (excluding real estate taxes)		38,051	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,080,746	\$ 2,118,797	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,900,000	1,900,000	39
40	Mortgage Payable		14,389,328	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,900,000	\$ 16,289,328	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,980,746	\$ 18,408,125	46
47	TOTAL EQUITY(page 18, line 24)	\$ (173,675)	\$ (860,678)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,807,071	\$ 17,547,447	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 384,361	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 384,361	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	341,964	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	(900,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (558,036)	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)	\$ (173,675)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NURSING & REHABILITAT # 0049759 Report Period Beginning: 1/1/09

Ending: 12/31/09

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,675,701	1
2	Discounts and Allowances for all Levels	(1,540,728)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,134,973	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,807,681	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,807,681	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	397,791	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,870	19
20	Radiology and X-Ray	2,419	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 411,080	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	773	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 773	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	761	28
28a	Miscellaneous	9,786	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,547	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,365,054	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,569,286	31
32	Health Care	6,498,280	32
33	General Administration	1,691,657	33
B. Capital Expense			
34	Ownership	1,801,540	34
C. Ancillary Expense			
35	Special Cost Centers	320,524	35
36	Provider Participation Fee	141,803	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,023,090	40
41	Income before Income Taxes (line 30 minus line 40)**	341,964	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 341,964	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number WEST SUBURBAN NURSING & REHABILITATION CE

0049759

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,034	2,146	\$ 115,089	\$ 53.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	48,615	54,587	1,663,221	30.47	3
4	Licensed Practical Nurses	29,932	33,130	866,220	26.15	4
5	CNAs & Orderlies	126,201	140,666	1,905,365	13.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,699	9,093	172,668	18.99	9
10	Activity Assistants					10
11	Social Service Workers	3,548	4,153	79,167	19.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,213	28,478	290,065	10.19	15
16	Dishwashers					16
17	Maintenance Workers	5,354	5,795	72,462	12.50	17
18	Housekeepers	22,525	24,237	225,698	9.31	18
19	Laundry	12,046	13,385	107,383	8.02	19
20	Administrator	2,001	2,112	107,957	51.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,267	11,373	215,004	18.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	296,435	329,155	\$ 5,820,299 *	\$ 17.68	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	549	\$ 19,220	1-3	35
36	Medical Director	Monthly	22,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	768	38,411	10-3	38
39	Pharmacist Consultant	84	4,207	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	45	1,582	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,446	\$ 86,020		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

SEE ACCOUNTANTS' COMPILATION REPORT

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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WEST SUBURBAN NURSING & REHABILITATION CENTER

0049759

Report Period Beginning: 1/1/09

Ending: 12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,529 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. \$ 141,803
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT