

Facility Name & ID Number WESTMONT CONVALESCENT CENTER

0030015 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 _____

	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	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,055	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,475	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,590	3,311	9,282	21,183	8
9	SNF/PED					9
10	ICF	38,218	11,599		49,817	10
11	ICF/DD			168	168	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,808	14,910	9,450	71,168	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.69%

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

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 09/01/85

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/85 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 43 and days of care provided 8,058

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **WESTMONT CONVALESCENT CENTER** # **0030015** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	314,915	24,862	7,047	346,824		346,824	0	346,824		1
2	Food Purchase		270,086		270,086		270,086	(16,378)	253,708		2
3	Housekeeping	288,630	44,786	0	333,416		333,416	0	333,416		3
4	Laundry	162,403	23,269	879	186,551		186,551	0	186,551		4
5	Heat and Other Utilities			263,578	263,578		263,578	447	264,025		5
6	Maintenance	86,574	45,316	21,932	153,822		153,822	1,072	154,894		6
7	Other (specify):* Security Salary	64,680		14,152	78,832		78,832	45	78,877		7
8	TOTAL General Services	917,202	408,319	307,588	1,633,109	0	1,633,109	(14,814)	1,618,295		8
	B. Health Care and Programs										
9	Medical Director	0		50,460	50,460		50,460	0	50,460		9
10	Nursing and Medical Records	2,931,422	152,579	23,764	3,107,765		3,107,765	0	3,107,765		10
10a	Therapy	136,294	652	1,211	138,157		138,157	0	138,157		10a
11	Activities	161,691	2,209	14,325	178,225		178,225	0	178,225		11
12	Social Services	109,376		1,047	110,423		110,423	0	110,423		12
13	CNA Training			2,304	2,304		2,304	0	2,304		13
14	Program Transportation			2,669	2,669		2,669	0	2,669		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	3,338,783	155,440	95,780	3,590,003	0	3,590,003	0	3,590,003		16
	C. General Administration										
17	Administrative	121,358		1,083,000	1,204,358		1,204,358	0	1,204,358		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			194,051	194,051		194,051	67	194,118		19
20	Dues, Fees, Subscriptions & Promotions			46,163	46,163		46,163	(17,310)	28,853		20
21	Clerical & General Office Expenses	179,133	27,823	24,362	231,318		231,318	84	231,402		21
22	Employee Benefits & Payroll Taxes			812,983	812,983		812,983	0	812,983		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			4,452	4,452		4,452	0	4,452		24
25	Other Admin. Staff Transportation			1,795	1,795		1,795	0	1,795		25
26	Insurance-Prop.Liab.Malpractice			210,351	210,351		210,351	190	210,541		26
27	Other (specify):*			49,075	49,075		49,075	(49,075)	0		27
28	TOTAL General Administration	300,491	27,823	2,426,232	2,754,546	0	2,754,546	(66,044)	2,688,502		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,556,476	591,582	2,829,600	7,977,658	0	7,977,658	(80,858)	7,896,800		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,580
	REPAIRS & MAINTENANCE	1,467
		0
		7,047
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	879
		0
		879
5	HEAT & OTHER UTILITIES	
	GAS HEAT	77,095
	ELECTRICITY	87,155
	WATER	99,328
	CABLE TV - LOBBY	
		0
		263,578
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,348
	PAINTING & DECORATING	1,882
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	4,648
	OUTSIDE LABOR	4,800
	EXTERMINATING SERVICE	4,625
	FIRE SERVICE	1,629
		0
		0
		0
		0
		21,932
7	OTHER	
	SCAVENGER	14,152
	SECURITY SERVICE	0
		0
		0
		14,152
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	50,460
		50,460

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	14,186
	PHARMACY CONSULTANT XVIII B 39-2	3,405
	UTILIZATION REVIEW FEES XVIII B ___-2	2,000
	PHYSICIANS XVIII B ___-2	329
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	NURSING PROGRAM CONSULTANT	3,844
		0
		23,764
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	1,211
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		1,211
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	13,401
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	924
		0
		14,325
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,047
		0
		1,047
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	2,304
		2,304

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	2,669
		2,669
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	1,083,000
		1,083,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	21,270
	ADMINISTRATIVE CONSULTANTS XIX C	138,140
	PROFESSIONAL FEES XIX C	34,641
		0
		194,051
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	10,626
	EMPLOYEE WANT ADS XIX F	19,530
	CONTRIBUTIONS VI 20 XIX F	250
	DUES & SUBSCRIPTIONS XIX F	6,808
	LICENSES & PERMITS XIX F	2,365
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	1,095
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	5,339
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	150
	PATIENT BACKGROUND CHECKS XIX F	0
		46,163
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	168
	EQUIPMENT REPAIR & MAINTENANCE	1,143
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	23,051
	MESSENGER SERVICE	0
		0
		24,362

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	345,072
	UNEMPLOYMENT COMPENSATION XIX D	70,784
	WORKERS COMPENSATION INSURANC XIX D	148,763
	HOSPITALIZATION INSURANCE XIX D	115,445
	EMPLOYEE BENEFITS - OTHER XIX D	129,594
	EMPLOYEE PHYSICAL EXAMS XIX D	3,325
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		812,983
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	4,452
	TRAVEL XIX G	0
		4,452
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,795
		1,795
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	210,351
		210,351
27	OTHER	
	BAD DEBTS VI 24	49,075
		49,075

GRAND TOTAL COLUMN 3 OTHER

2,829,600

WESTMONT CONVALESCENT CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	270,086	PATIENT MEALS	213504
LESS SALES TAX	(997)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	269,089	TOTAL MEALS/YEAR	213504
TOTAL PATIENT CENSUS	71,168	NET FOOD	269089
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	213504

TOTAL PATIENT MEALS	213504	COST PER MEAL	1.26
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number WESTMONT CONVALESCENT CENTER

#0030015

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			275,150	275,150		275,150	7,426	282,576			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			1,238,803	1,238,803		1,238,803	(18,749)	1,220,054			32
33	Real Estate Taxes			92,056	92,056		92,056	1,893	93,949			33
34	Rent-Facility & Grounds			44,000	44,000		44,000	(44,000)	0			34
35	Rent-Equipment & Vehicles			71,299	71,299		71,299	434	71,733			35
36	Other (specify):* Amor Def Mortg			91,970	91,970		91,970	(14,835)	77,135			36
37	TOTAL Ownership			1,813,278	1,813,278	0	1,813,278	(67,831)	1,745,447			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		274,535	317,558	592,093		592,093	0	592,093			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			117,713	117,713		117,713	0	117,713			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	274,535	435,271	709,806	0	709,806	0	709,806			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,556,476	866,117	5,078,149	10,500,742	0	10,500,742	(148,689)	10,352,053			45

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

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	OHF 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	(9,853)	30		9
10	Interest and Other Investment Income	(47,991)	32		10
11	Discounts, Allowances, Rebates & Refunds	(15,381)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(997)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,095)	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(5,589)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,075)	27		24
25	Fund Raising, Advertising and Promotional	(10,626)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	256			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (140,351)		\$ 0	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)	(8,338)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (8,338)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (148,689)		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	Exceptional Care Program		X			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	
----	--	----	--	----	--	----	--	----	--

ID# 0030015

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 256	6 1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	256	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTMONT CONVALESCENT CENTER

0030015

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(16,378)	0	0	0	0	0	0	0	0	0	0	(16,378)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	447	0	0	0	0	0	0	0	0	447	5
6	Maintenance	256	0	816	0	0	0	0	0	0	0	0	1,072	6
7	Other (specify):*	0	0	45	0	0	0	0	0	0	0	0	45	7
8	TOTAL General Services	(16,122)	0	1,308	0	(14,814)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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	0	67	0	0	0	0	0	0	0	0	67	19
20	Fees, Subscriptions & Promotions	(17,310)	0	0	0	0	0	0	0	0	0	0	(17,310)	20
21	Clerical & General Office Expenses	0	0	84	0	0	0	0	0	0	0	0	84	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	190	0	0	0	0	0	0	0	0	190	26
27	Other (specify):*	(49,075)	0	0	0	0	0	0	0	0	0	0	(49,075)	27
28	TOTAL General Administration	(66,385)	0	341	0	(66,044)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,507)	0	1,649	0	(80,858)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	(9,853)	15,969	1,310	0	0	0	0	0	0	0	0	7,426	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(47,991)	26,604	2,638	0	0	0	0	0	0	0	0	(18,749)	32
33	Real Estate Taxes	0	0	1,893	0	0	0	0	0	0	0	0	1,893	33
34	Rent-Facility & Grounds	0	(44,000)	0	0	0	0	0	0	0	0	0	(44,000)	34
35	Rent-Equipment & Vehicles	0	0	434	0	0	0	0	0	0	0	0	434	35
36	Other (specify):*	0	0	(14,835)	0	0	0	0	0	0	0	0	(14,835)	36
37	TOTAL Ownership	(57,844)	(1,427)	(8,560)	0	(67,831)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(140,351)	(1,427)	(6,911)	0	(148,689)	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
				WESTMONT REAL ESTATE, LLC	LINCOLNWOOD	REAL ESTATE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				IME REALTY CORP	LINCOLNWOOD	HOME OFFICE

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 44,000	WESTMONT REAL ESTATE, LLC		\$	(44,000)	1
2	V	30 DEPRECIATION (SL)				15,969	15,969	2
3	V	32 INTEREST				26,604	26,604	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 44,000			\$ 42,573	\$ * (1,427)	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	36 OFFICE RENT	\$ 14,835	IME REALTY CORP		\$	(14,835)
16	V	5 UTILITIES				447	447
17	V	6 REPAIRS/MAINT				816	816
18	V	7 ALARM SERVICE				45	45
19	V	19 PROFESSIONAL FEES				67	67
20	V	21 OFFICE EXPENCE				84	84
21	V	26 INSURANCE				190	190
22	V	30 DEPRECIATION (SL)				1,310	1,310
23	V	32 INTEREST				2,638	2,638
24	V	33 RE TX				1,893	1,893
25	V	35 STORAGE FEES				434	434
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		\$ 14,835			\$ 7,924	\$ * (6,911)

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

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	FLORA WEISS	GEN. PARTNER	ADMINISTRAT	0.22	SEE ATTACHED			MGMT FEE	\$ 541,500	17-3	1
2	DANIEL WEISS	ADMINISTRATOR	ADMINISTRAT	0.00	SEE ATTACHED			SALARY	163,140	17-1	2
3	SHIRLEY HOLT	GEN. PARTNER	ADMINISTRAT	0.16	SEE ATTACHED			MGMT FEE	541,500	17-3	3
4	RICHARD HOLT	SECURITY	SECURITY	0.00	SEE ATTACHED			OUTS. LAB	4,800	6-3	4
5	CAROLYN HOLT	CLERK	CLERICAL	0.00				SALARY	9,600	21-1	5
6	SHARON HAUGH	BOOKKEEPER	CLERICAL	0.09	SEE ATTACHED			SALARY	46,286	21-1	6
7	JANE HOLT	MDS COMP INPUT	COMP INPUT	0.00				SALARY	12,000	10-1	7
8	VASCO HOLD	CLERK	IN SERV TRAIN	0.00				SALARY	25,200	10-1	8
9	AVRUM WEINFELD	CONSULTANT	COMP CONS	0.00	SEE ATTACHED			SALARY	24,200	21-1	9
10											10
11											11
12											12
13								TOTAL	\$ 1,368,226		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 WESTMONT CONVALESCENT CENTER

0030015

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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

Name of Related Organization IME REALTY CORP.
 Street Address 6765 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847)674-5795
 Fax Number (847) 674-5794

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

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	5	UTILITIES	PATIEN DAYS	344,402	15	\$ 10,404	\$ 14,835	\$ 447	1
2	6	REPAIRS/MAINT	PATIEN DAYS	344,402	15	18,957	14,835	816	2
3	7	ALARM SERVICE	PATIEN DAYS	344,402	15	1,056	14,835	45	3
4	19	PROFESSIONAL FEES	PATIEN DAYS	344,402	15	1,575	14,835	67	4
5	21	OFFICE EXPENCE	PATIEN DAYS	344,402	15	1,942	14,835	84	5
6	26	INSURANCE	PATIEN DAYS	344,402	15	4,387	14,835	190	6
7	30	DEPRECIATION (SL)	PATIEN DAYS	344,402	15	30,446	14,835	1,310	7
8	32	INTEREST	PATIEN DAYS	344,402	15	61,229	14,835	2,638	8
9	33	RE TX	PATIEN DAYS	344,402	15	43,904	14,835	1,893	9
10	35	STORAGE FEES	PATIEN DAYS	344,402	15	10,073	14,835	434	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					\$ 183,973	\$	\$ 7,924	25

Facility Name & ID Number WESTMONT CONVALESCENT CENTER# 0030015

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**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	Name of Lender	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	KEY COMMERCIAL		x	MORTGAGE	\$87,556.00	05/01/98	\$ 10,000,000	\$ 0		7.2800	\$ 1,235,942	1						
2	RELATED PARTY: WESTMONT REAL ESTATE, LLC											2						
3	CAMBRIDGE REALTY		X	MORTGAGE	\$77,424.00	11/17/06	10,881,400	10,881,400	12/01/41	5.9800	25,305	3						
4	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		348,110	346,811			1,299	4						
5												5						
	Working Capital																	
6	BANK FINANCIAL		X	LOAN		10/03/06	409,000	0		5.4000	2,861	6						
7												7						
8	IME REALTY ALLOCATION										2,638	8						
9	TOTAL Facility Related				\$164,980.00		\$ 21,638,510	\$ 11,228,211			\$ 1,268,045	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 21,638,510	\$ 11,228,211			\$ 1,268,045	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.

\$ **92,399** 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.)

\$ **91,769** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(631)** 3

4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **92,687** 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.

\$ **92,056** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	81,217	8
	2002	82,311	9
	2003	84,637	10
	2004	89,708	11
	2005	91,769	12

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTMONT CONVALESCENT CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0030015

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-22-101-001</u>	<u>NURSING HOME</u>	\$ <u>87,433.32</u>	\$ <u>87,433.32</u>
2. <u>09-22-101-002</u>	<u>NURSING HOME</u>	\$ <u>4,336.02</u>	\$ <u>4,336.02</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>91,769.34</u>	\$ <u>91,769.34</u>

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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 WESTMONT CONVALESCENT CENTER

0030015

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928 B. General Construction Type: Exterior BRICK Frame STEEL 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.
 (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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).

N/A

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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1			<u>1995</u>	<u>\$ 349,103</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 349,103	3

Facility Name & ID Number WESTMONT CONVALESCENT CENTER

0030015

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	215	1995		\$ 4,982,301	\$ 127,751	39	\$ 127,751	\$	\$ 1,506,521	4
5										5
6										6
7										7
8	IME REALTY ALLOC			49,471	1,259		1,259			8
	Improvement Type**									
9	FLOORING		1986	41,641		19	698	698	41,641	9
10	ROOF & WATER LINE		1987	31,143	989	20	1,557	568	30,354	10
11	IMPROVEMENTS		1988	44,614	1,416	31.5	1,416		26,191	11
12	IMPROVEMENTS		1989	40,935	1,299	31.5	1,299		22,674	12
13	DRIVEWAY		1989	17,137		15	1,142	1,142	16,890	13
14	IMPROVEMENTS		1990	37,367	1,186	31.5	1,186		19,518	14
15	IMPROVEMENTS		1991	45,002	1,428	31.5	1,428		21,895	15
16	IMPROVEMENTS		1992	49,649	1,577	31.5	1,577		22,773	16
17	ROOF TOP A/C UNITS		1993	9,100	289	31.5	289		4,022	17
18	IMPROVEMENTS		1993	53,243	1,366	39	1,366		18,291	18
19	IMPROVEMENTS		1994	31,230	801	39	801		10,129	19
20	FLOOR COVERING		1995	795	20	15	53	33	636	20
21	HAND RAIL		1995	2,249	58	39	58		689	21
22	FLOOR TILES		1995	5,471	140	39	140		1,628	22
23	WINDOW A/C UNITS		1995	14,146	363	39	363		4,158	23
24	ARJO TUB & ATTACHED PLUMBING		1995	12,056	309	39	309		3,567	24
25	ALARM		1995	1,337	34	39	34		390	25
26	LAUNDRY BUILDING		1995	35,000	897	39	897		10,129	26
27	ROOF		1995	5,520	142	39	142		1,603	27
28	WINDOWS		1995	9,478	243	39	243		2,724	28
29	DOOR EDGE & DOOR FRAME		1996	2,099	54	39	54		592	29
30	LAUNDRY BUILDING		1996	175,187	4,491	39	4,491		47,353	30
31	AIR COOLERS		1996	6,642	171	39	171		1,793	31
32	RACING CAGE		1996	3,987	102	39	102		1,075	32
33	HAND RAIL		1996	1,156	30	39	30		311	33
34	WINDOWS		1996	11,496	295	39	295		3,061	34
35	TACK ROOM		1996	2,139	55	39	55		566	35
36	NEW CONFERENCE ROOM-TILE		1997	2,938	76	39	76		706	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 WESTMONT CONVALESCENT CENTER

0030015

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALL DIETARY DOOR	1997	\$ 1,478	\$ 38	39	\$ 38		\$ 353	37
38	NURSING STATION - 2ND FLOOR	1997	5,397	138	39	138		1,260	38
39	WINDON-NURSING OFFICE	1997	1,382	35	39	35		319	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107	28	39	28		279	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927	126	39	126		1,098	41
42	THE PARKING LOT	1998	42,711	2,990	15	2,990		23,728	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223	160	39	160		1,423	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715	326	39	326		2,649	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473	269	39	269		2,141	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452	89	39	89		686	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495	38	39	38		293	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877	74	39	74		564	48
49	REMODELING F WING SHOWER ROOM	1999	8,988	230	39	230		1,735	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370	61	39	61		455	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760	71	39	71		512	51
52	WATER HEATER - DIETARY	1999	2,931	75	39	75		534	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073	79	39	79		563	53
54	TILE - DINING ROOM	1999	1,212	31	39	31		221	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200	185	39	185		1,318	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738	70	39	70		493	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265	286	20	163	(123)	1,141	57
58	WATER HEATER - DIETARY	2000	3,573	130	27.5	130		818	58
59	GENERAL CONSTRUCTION	2000	27,448	998	27.5	998		6,196	59
60	ROOF REPAIR	2000	4,200	153	27.5	153		950	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910	106	27.5	106		640	61
62	NEW A/C UNIT ROOF TOP	2000	4,694	171	27.5	171		1,033	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523	7,049	20	4,026	(3,023)	28,182	63
64	SHOWER ROOM RENOVATIONS	2001	30,586	1,112	27.5	1,112		6,441	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341	3,903	27.5	3,903		20,979	65
66	WATER HEATER - LAUNDRY	2001	9,108	331	27.5	331		1,669	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464	453	27.5	453		2,284	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861	24,547	20	13,543	(11,004)	81,258	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114	2,979	20	1,456	(1,523)	7,280	69
70	TOTAL (lines 4 thru 69)		\$ 6,436,125	\$ 194,172		\$ 180,940	\$ (13,232)	\$ 2,021,375	70

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

Facility Name & ID Number WESTMONT CONVALESCENT CENTER

0030015

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,436,125	\$ 194,172		\$ 180,940	\$ (13,232)	\$ 2,021,375	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997	630	15	600	(30)	2,580	2
3	SHOWER ROOM	2002	30,924	1,125	27.5	1,125		4,734	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010	328	27.5	328		1,326	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891	541	27.5	541		2,187	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056	3,991	20	2,003	(1,988)	10,015	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499	1,146	20	575	(571)	2,875	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767	464	27.5	464		1,605	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152	1,133	27.5	1,133		3,918	9
10	THERAPY ROOM -FLOORING	2003	87,509	3,182	27.5	3,182		11,004	10
11	CONFERENCE ROOM-FLOORING	2003	2,073	76	27.5	76		263	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421	270	27.5	270		664	12
13	TONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825	3,266	27.5	3,266		7,485	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925	1,852	27.5	1,852		4,090	14
15	RESIDENT ROOMS-FLOORING	2005	9,821	357	27.5	357		610	15
16	INSTALL CABLING SYSTEM	2005	46,771	1,701	27.5	1,701		2,764	16
17	INSTALL TWO AUTOMATIC SLIDING DOOR	2005	28,000	1,018	27.5	1,018		1,060	17
18	1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE	2005	58,286	18,652	20	2,914	(15,738)	5,828	18
19	INSTALL DOORS - F WING, RESIDENT ROOMS	2006	4,260	136	27.5	136		136	19
20	WALLCOVERING, FLOORING - 1ST FLOOR CORRID	2006	63,838	1,837	27.5	1,837		1,837	20
21	AIR CONDITIONS	2006	7,968	140	27.5	140		140	21
22	REPLACEMENT WALK - IN FREEZER DOOR	2006	4,652	92	27.5	92		92	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,056,770	\$ 236,109		\$ 204,550	\$ (31,559)	\$ 2,086,588	34

**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	\$ 703,234	\$ 45,499	\$ 73,961	\$ 28,462		\$ 504,605	71
72	Current Year Purchases	80,272	10,770	4,014	(6,756)		4,014	72
73	Fully Depreciated Assets	1,749,516			0		1,749,516	73
74	IME REALTY SL DEPR		51	51	0			74
75	TOTALS	\$ 2,533,022	\$ 56,320	\$ 78,026	\$ 21,706		\$ 2,258,135	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	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)	\$ 9,938,895	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 292,429	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 282,576	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,853)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,344,723	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: **N/A-RELATED PARTY**

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: \$ **29,731** Description: **SEE SCHEDULE ATTACHED**

(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	ADMINISTRATIVE	2001 BMW	\$ #####	\$ 12,780	17
18	ADMINISTRATIVE	2004 LEXUS	#####	12,588	18
19	ADMINISTRATIVE	2005 TOYOTA	575.00	6,900	19
20	HSKP, MAINT	2004 FORD PASS VAN	775.00	9,300	20
21	TOTAL		\$ #####	\$ 41,568	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.	/2007	\$ _____
13.	/2008	\$ _____
14.	/2009	\$ _____

* 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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>130</u></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	\$	\$ 865	\$	\$ 865
2	Books and Supplies		1,439		1,439
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 2,304	\$ 0	\$ 2,304
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,304			

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	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

- (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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 144,791	\$		\$ 144,791	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,926			21,926	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			150,841			150,841	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 prescripts				241,446		241,446	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Lab,Radiology,Tube feeding Other (specify): Medical Supplies	39-2 39-2					26,337 6,752		26,337 6,752	13
14	TOTAL			\$		\$ 317,558	\$ 274,535		\$ 592,093	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 WESTMONT CONVALESCENT CENTER

0030015

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 759,087	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 30,000)	1,947,118		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	304,848		6
7	Other Prepaid Expenses	39,835		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,050,888	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,024,998		15
16	Equipment, at Historical Cost	2,533,023		16
17	Accumulated Depreciation (book methods)	(3,293,511)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction escrow</u>	1,500		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,266,010	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,316,898	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 169,501	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	831		28
29	Short-Term Notes Payable	5,148,025		29
30	Accrued Salaries Payable	162,488		30
31	Accrued Taxes Payable (excluding real estate taxes)	67,802		31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,687		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)	\$ 5,641,334	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,641,334	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,324,436)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,316,898	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (811,268)	1
2	Restatements (describe):		2
3	ROUNDING	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (811,262)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	448,951	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	(962,125)	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)	\$ (513,174)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,324,436)	24 *

* This must agree with page 17, line 47.

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	\$ 10,666,454	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,666,454	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	175,972	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 175,972	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	13,693	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,693	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	47,991	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 47,991	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COMPUTER INCOME	49,800	28
28a	DISCOUNTS EARNED	15,381	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 65,181	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,969,291	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,633,109	31
32	Health Care	3,590,003	32
33	General Administration	2,754,546	33
	B. Capital Expense		
34	Ownership	1,813,278	34
	C. Ancillary Expense		
35	Special Cost Centers	592,093	35
36	Provider Participation Fee	117,713	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,500,742	40
41	Income before Income Taxes (line 30 minus line 40)**	468,549	41
42	Income Taxes	(19,598)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 448,951	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** 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 WESTMONT CONVALESCENT CENTER

0030015

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	3,149	3,758	\$ 87,912	\$ 23.39	1
2	Assistant Director of Nursing	2,277	2,718	63,585	23.39	2
3	Registered Nurses	39,232	41,350	1,135,251	27.45	3
4	Licensed Practical Nurses	7,913	8,561	201,511	23.54	4
5	CNAs & Orderlies	110,109	113,587	1,154,063	10.16	5
6	CNA Trainees					6
7	Licensed Therapist	163	179	5,200	29.05	7
8	Rehab/Therapy Aides	8,174	9,213	131,094	14.23	8
9	Activity Director	4,188	4,743	69,876	14.73	9
10	Activity Assistants	10,658	11,082	91,815	8.29	10
11	Social Service Workers	6,461	6,978	109,376	15.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,957	30,855	314,915	10.21	15
16	Dishwashers					16
17	Maintenance Workers	6,181	6,561	86,574	13.20	17
18	Housekeepers	37,467	38,932	288,630	7.41	18
19	Laundry	20,892	21,935	162,403	7.40	19
20	Administrator	1,317	1,408	29,225	20.76	20
21	Assistant Administrator	3,834	4,008	92,133	22.99	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,437	14,895	179,133	12.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,881	3,023	42,496	14.06	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	14,651	16,177	246,604	15.24	31
32	Other Health Care(specify)					32
33	Other(specify) <u>SECURITY</u>	2,393	2,394	64,680	27.02	33
34	TOTAL (lines 1 - 33)	325,334	342,357	\$ 4,556,476 *	\$ 13.31	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	Monthly Fees	\$ 5,580	1-3	35
36	Medical Director	Monthly Fees	50,460	9-3	36
37	Medical Records Consultant	Monthly Fees	14,186	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly Fees	3,405	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	16	924	11-3	44
45	Social Service Consultant	19	1,047	12-3	45
46	Other(specify) <u>Physicians & Rehab</u>	21	1,540	10-3	46
47	<u>Utilization Review Fees</u>	Monthly Fees	2,000	10-3	47
48	<u>Nursing Program Consultant</u>	62	3,844	10-3	48
49	TOTAL (lines 35 - 48)	118	\$ 82,986		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	N/A		10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$								
2	PAIN/DECORATING	7/03	2,188	3 YRS	365	729	729	365				
3	PAIN/DECORATING	7/04	2,834	3 YRS		472	945	945	472			
4	PAIN/DECORATING	7/05	1,544	3 YRS			258	514	514	258		
5	PAIN/DECORATING	7/06	1,882	3 YRS				314	627	627	314	
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 8,448		\$ 365	\$ 1,201	\$ 1,932	\$ 2,138	\$ 1,613	\$ 885	\$ 314	\$

Facility Name & ID Number WESTMONT CONVALESCENT CENTER

0030015

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$6738
- (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? _____
- (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? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,091 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. _____
- (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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
WESTMONT TERRACE NURSING CENTER, #0025981 09/1/85
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 117,713
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. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees