

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0019489

Facility Name: Manorcare at Westmont

Address: 512 East Ogden Avenue Westmont 60559
 Number City Zip Code

County: DuPage

Telephone Number: (630) 323-4400 **Fax #** (630) 323-4583

HFS ID Number: 520970446001

Date of Initial License for Current Owners: 05/01/77

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Gary Geise **Telephone Number:** (419) 252-5731

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/06 to 05/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Barry A. Lazarus</u>	
	(Title) <u>Vice President, Reimbursement</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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

Facility Name & ID Number Manorcare at Westmont# 0019489 Report Period Beginning: 06/01/06 Ending: 05/31/07

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	<u>155</u>	Skilled (SNF)	<u>155</u>	<u>56,575</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>155</u>	TOTALS	<u>155</u>	<u>56,575</u>	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	<u>14,128</u>	<u>11,160</u>	<u>24,159</u>	<u>49,447</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>14,128</u>	<u>11,160</u>	<u>24,159</u>	<u>49,447</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.40%

D. How many bed-hold days during this year were paid by the Department?

16 (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)

NoneF. 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 05/01/77

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 155 and days of care provided 19,036Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/07 Fiscal Year: 5/31/07

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

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/06 Ending: 05/31/07

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	347,593	34,512	2,132	384,237	4,027	388,264		388,264		1
2	Food Purchase		277,583		277,583		277,583	(821)	276,762		2
3	Housekeeping	172,297	29,384	1,294	202,975		202,975		202,975		3
4	Laundry	56,001	16,307	4,018	76,326		76,326		76,326		4
5	Heat and Other Utilities			208,238	208,238	9,438	217,676		217,676		5
6	Maintenance	46,830	32,285	59,175	138,290		138,290		138,290		6
7	Other (specify):* Medical Waste			3,992	3,992		3,992		3,992		7
8	TOTAL General Services	622,721	390,071	278,849	1,291,641	13,465	1,305,106	(821)	1,304,285		8
	B. Health Care and Programs										
9	Medical Director			47,850	47,850		47,850		47,850		9
10	Nursing and Medical Records	3,895,385	301,179	53,472	4,250,036	6,379	4,256,415		4,256,415		10
10a	Therapy	441,829	14,065	907,192	1,363,086		1,363,086	(25,003)	1,338,083		10a
11	Activities	115,386	4,198	1,710	121,294		121,294		121,294		11
12	Social Services	84,368	495	438	85,301		85,301		85,301		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,536,968	319,937	1,010,662	5,867,567	6,379	5,873,946	(25,003)	5,848,943		16
	C. General Administration										
17	Administrative	66,834		571,088	637,922	(113,215)	524,707		524,707		17
18	Directors Fees										18
19	Professional Services			10,349	10,349		10,349	(10,349)			19
20	Dues, Fees, Subscriptions & Promotions			194,035	194,035		194,035	(43,720)	150,315		20
21	Clerical & General Office Expenses	437,744	59,236	198,064	695,044		695,044	(142,384)	552,660		21
22	Employee Benefits & Payroll Taxes			835,244	835,244	69,598	904,842		904,842		22
23	Inservice Training & Education			2,838	2,838		2,838		2,838		23
24	Travel and Seminar			17,021	17,021		17,021		17,021		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			159,135	159,135		159,135		159,135		26
27	Other (specify):*										27
28	TOTAL General Administration	504,578	59,236	1,987,774	2,551,588	(43,617)	2,507,971	(196,453)	2,311,518		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,664,267	769,244	3,277,285	9,710,796	(23,773)	9,687,023	(222,277)	9,464,746		29

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

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

Facility Name & ID Number Manorcare at Westmont #0019489 Report Period Beginning: 06/01/06 Ending: 05/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			648,171	648,171	23,773	671,944	671,944			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			15	15		15	15			32
33	Real Estate Taxes			114,690	114,690		114,690	114,690			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			104,457	104,457		104,457	104,457			35
36	Other (specify):*										36
37	TOTAL Ownership			867,333	867,333	23,773	891,106	891,106			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			58	58		58	58			38
39	Ancillary Service Centers		781,755		781,755		781,755	781,755			39
40	Barber and Beauty Shops			18,863	18,863		18,863	18,863			40
41	Coffee and Gift Shops	22,573			22,573		22,573	22,573			41
42	Provider Participation Fee			84,863	84,863		84,863	84,863			42
43	Other (specify):* IV Therapy & X-Ray		129,354	42,909	172,263		172,263	172,263			43
44	TOTAL Special Cost Centers	22,573	911,109	146,693	1,080,375		1,080,375	1,080,375			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,686,840	1,680,353	4,291,311	11,658,504		11,658,504	(222,277)	11,436,227		45

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

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	(821)	2		4
5	Telephone, TV & Radio in Resident Rooms	(17)	21		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
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(453)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(310)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,349)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(140,208)	21		24
25	Fund Raising, Advertising and Promotional	(43,720)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,396)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (197,274)		\$	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)	(25,003)	10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (25,003)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (222,277)		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		52

Manorcare at Westmont

ID# 0019489

Report Period Beginning: 06/01/06

Ending: 05/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (1,305)	21	1
2	Misc. Income	(91)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,396)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning:

06/01/06

Ending:

05/31/07

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(821)	0	0	0	0	0	0	0	0	0	0	(821)	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	0	0	0	0	0	0	0	0	0	0	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	(821)	0	0	0	0	0	0	0	0	0	0	(821)	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	(25,003)	(25,003)	0	0	0	0	0	0	0	0	0	(50,006)	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	(25,003)	(25,003)	0	(50,006)	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	(10,349)	0	0	0	0	0	0	0	0	0	0	(10,349)	19
20	Fees, Subscriptions & Promotions	(43,720)	0	0	0	0	0	0	0	0	0	0	(43,720)	20
21	Clerical & General Office Expenses	(142,384)	0	0	0	0	0	0	0	0	0	0	(142,384)	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	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(196,453)	0	0	0	0	0	0	0	0	0	0	(196,453)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(222,277)	(25,003)	0	(247,280)	29								

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Westmont

0019489 Report Period Beginning:

06/01/06 Ending:

Summary B

05/31/07

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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)	(222,277)	(25,003)	0	(247,280)	45								

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning:

06/01/06

Ending:

05/31/07

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
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)				

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	See Home Iffuce Allocation	\$ 571,088	HCR Manor Care, Inc.	100.00%	\$ 571,088	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	39,185	Heartland Management Services	100.00%	39,185		6
7	V							7
8	V	10a Therapy PT, OT, & ST	833,434	Heartland Rehab Services	100.00%	808,431	(25,003)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,443,707			\$ 1,418,704	\$ * (25,003)	14

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

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/06 Ending: 05/31/07

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning: 06/01/06

Ending: 05/31/07

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 HCR Manor Caer, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH 43604-2617
 Phone Number (419) 252-5500
 Fax Number (419) 254-5495

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	1	Dietary - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac	\$ 0	\$ 0	11,255,541	\$ 0	1
2	1	Dietary - Polled	Accumulated Cost	3,232,621,368	369 Nurs. Fac	1,156,548	325,878	11,255,541	4,027	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac	500,452	0	11,255,541	2,162	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac	2,089,736	0	11,255,541	7,276	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac	0	0	11,255,541	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac	1,831,963	1,296,078	11,255,541	6,379	6
7	17	Gen & Admin - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac	41,206,110	32,327,667	11,255,541	178,041	7
8	17	Gen & Admin - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac	80,368,229	42,462,992	11,255,541	279,832	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac	8,458,198	0	11,255,541	36,546	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac	9,492,678	0	11,255,541	33,052	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac	0	0	11,255,541	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac	6,827,559	0	11,255,541	23,773	12
13										13
14	32	Interest				4,662,634			0	14
15		Non-Nursing Home Allocations				22,389,200				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 178,983,307	\$ 76,412,615		\$ 571,088	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8	Interest Expense / Income									(123)										
9	TOTAL Facility Related									(123)										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)									(123)										

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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Westmont COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0019489

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>09-03-207-014</u>	<u>See Attached</u>	\$ <u>111,077.88</u>	\$ <u>111,077.88</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>111,077.88</u>	\$ <u>111,077.88</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Manorcare at Westmont

0019489 Report Period Beginning:

06/01/06 Ending:

05/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,189 B. General Construction Type: Exterior Masonry 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).

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1977</u>	<u>\$ 195,699</u>	<u>1</u>
2	<u>Facility Addition</u>		<u>2004</u>	<u>33,809</u>	<u>2</u>
3	TOTALS			\$ 229,508	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1977	\$ 1,372,073	\$ 80,681		\$ 80,681		\$ 1,176,738	4
5				2004	1,903,806						5
6											6
7											7
8											8
Improvement Type**											
9	Current Year Depreciation					416,307		416,307		2,473,227	9
10				1985	42,165						10
11				1986	9,808						11
12				1987	118,541						12
13				1988	118,593						13
14				1989	58,768						14
15				1990	15,910						15
16				1991	58,674						16
17				1992	84,338						17
18				1993	50,656						18
19				1994	697,677						19
20				1995	184,192						20
21				1996	118,190						21
22				1997	90,456						22
23				1998	253,224						23
24				1999	3,181						24
25				2000	85,888						25
26				2001	224,426						26
27		VINYL WALLCOVERING		2002	1,404						27
28		WINDOW TREATMENTS		2002	907						28
29		PAINT, WVC, & CARPET		2002	8,512						29
30		INSTALL PHONE JACKS		2002	476						30
31		ELECTRIC WORK & FIXTURES		2002	2,699						31
32		CONSTRUCTION OF NEW INTERIOR WALL		2002	1,930						32
33		CONCRETE / RETAINING WALL		2002	11,871						33
34		STORAGE ROOM		2003	6,740						34
35		VINYL WALLCOVERING		2003	7,131						35
36				2003	1,744						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 Manorcare at Westmont

0019489

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	CONSTRUCTION DEPT. COST & INTEREST	2003	\$ 3,554	\$		\$	\$	37
38	WALLCOVERING & CARPET	2003	16,639					38
39	CABINETRY - CUSTON MADE & INSTALLED	2003	4,875					39
40	WINDOWS INSTALLED & EXTEND WALL	2003	14,827					40
41	BIFOLD OPERATOR DOOR	2003	2,446					41
42	WALLCOVERING & CARPET	2004	2,250					42
43	General Build Overhead & Interest	2004	117,867					43
44	Carpentry	2004	26,990					44
45	Mill Work	2004	4,207					45
46	Doors & Frames	2004	24,238					46
47	Windows	2004	10,470					47
48	Flooring	2004	1,012					48
49	Wallcovering & Corner Guards	2004	99,668					49
50	Fire Sprinkler System	2004	800					50
51	Plumbing	2004	1,626					51
52	Electrical	2004	4,889					52
53	Bldg Addtn - Architect, Engineering, Permits, Plan Reviews	2004	223,090					53
54	Bldg Addtn - General Overhead Costs & Interest	2004	616,107					54
55	Bldg Addtn - Carpeting	2004	21,109					55
56	Bldg Addtn - Wallcovering & Corner Guards	2004	25,299					56
57	Bldg Addtn - Millwork	2004	11,524					57
58	Bldg Addtn - Soil & Concrete Testing, Water & Sewer Fees	2004	108,430					58
59	Bldg Addtn - Land Prep/Improvements for Construction	2004	284,371					59
60	Bldg Addtn - Paving	2004	57,718					60
61	Garage Renov. - Roof, Decking, Door, Siding, Soffits	2004	9,820					61
62	Doors	2004	13,114					62
63	Repair Wall & VWC	2004	7,292					63
64	Door Hardware	2005	5,800					64
65	fire caulking	2005	13,665					65
66	Additional cost for caulking	2005	1,765					66
67	New Door	2005	1,694					67
68	Feed for Door Operator	2005	550					68
69	New Doors	2005	8,861					69
70	TOTAL (lines 4 thru 69)		\$ 7,280,547	\$ 496,988		\$ 496,988	\$ 3,649,965	70

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

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning:

06/01/06

Ending:

05/31/07

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		\$ 7,280,547	\$ 496,988		\$ 496,988	\$	\$ 3,649,965	1
2	Doors	2005	3,179						2
3	Service Doors	2005	3,179						3
4	Renov - Genreal Overhead & interest	2005	26,091						4
5	Renov - Resilient Flooring	2005	90,087						5
6	Renov - Wallcovering	2005	5,644						6
7	Renov - Carpentry - Subpcontr	2005	10,000						7
8	Renov - Fire Sprinkler System	2005	4,125						8
9	Renov - Wood Doors & Frames	2005	22,840						9
10	Renov - Accoustical Ceiling Tiles	2005	2,500						10
11	New Door & Thresholds	2006	3,200						11
12	Vinyl Covering & Flooring	2005	2,971						12
13	Doors	2006	1,066						13
14	Light poles & base	2005	3,300						14
15	Doors cost adjustment /duplicate	2005	(3,179)						15
16	Renov - general overhead & interest	2006	11,813						16
17	Renov - basic electrical - elevator	2006	60,598						17
18	countertop	2006	1,040						18
19	120V feed	2006	1,118						19
20	ductwork	2006	4,930						20
21	40 beds / assist rails	2006	11,328						21
22	2 resident room doors	2007	1,400						22
23	5 resident room doors	2007	6,300						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)		\$ 7,554,078	\$ 496,988		\$ 496,988	\$	\$ 3,649,965	34

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

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/06 Ending: 05/31/07

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	\$ 2,122,820	\$ 151,183	\$ 151,183	\$		\$ 1,468,663	71
72	Current Year Purchases	138,929						72
73	Fully Depreciated Assets							73
74	Home office & Retirements			23,773	23,773			74
75	TOTALS	\$ 2,261,749	\$ 151,183	\$ 174,956	\$ 23,773		\$ 1,468,663	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				\$	\$	\$	\$		\$	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)	\$	10,045,335	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	648,171	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	671,944	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	23,773	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	5,118,628	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning: 06/01/06

Ending: 05/31/07

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 104,457 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elec. Beds, Etc.

(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	N/A		\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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.

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	10a	2232 hrs	\$ 74,142	6,266	\$ 308,280		8,498	\$ 382,422	1
2	Licensed Speech and Language Development Therapist	10a	1193 hrs	44,827	1,755	86,360		2,948	131,187	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	1708 hrs	60,688	9,417	463,340		11,125	524,028	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				781,755		781,755	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Inhal Ther/X-Ray/Lab</u>	10a	39	993			129,354	39	130,347	13
14	TOTAL			\$ 180,650	17,438	\$ 857,980	\$ 911,109	22,610	\$ 1,949,739	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 Manorcare at Westmont# 0019489Report Period Beginning: 06/01/06

Ending:

05/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 05/31/07

(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	\$ 77,002	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (283,427))	2,450,213		3
4	Supply Inventory (priced at <u>3/31/07</u>)	44,295		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,419		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,585,929	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	229,508		13
14	Buildings, at Historical Cost	7,554,078		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,261,749		16
17	Accumulated Depreciation (book methods)	(5,118,628)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,926,707	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,512,636	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,111	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	574,711		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	102,747		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	235,356		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 935,925	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	9,996		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)	\$ 9,996	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 945,921	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 6,566,715	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,512,636	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,873,089	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,873,089	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,125,565	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	()	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)	\$ 2,125,565	17
B. Transfers (Itemize):			
18	Change in Interdivision	(2,431,939)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,431,939)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,566,715	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Westmont# 0019489Report Period Beginning: 06/01/06Ending: 05/31/07**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	\$ 11,528,505	1
2	Discounts and Allowances for all Levels	(2,396,961)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,131,544	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,741,623	6
7	Oxygen	36,991	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,778,614	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	1,305	12
13	Barber and Beauty Care	22,237	13
14	Non-Patient Meals	821	14
15	Telephone, Television and Radio	17	15
16	Rental of Facility Space		16
17	Sale of Drugs	741,078	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	47,824	19
20	Radiology and X-Ray	3,885	20
21	Other Medical Services	47,052	21
22	Laundry	9,972	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 874,191	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Inc & Purch Disc</u>	(362)	28
28a	<u>Late Charges</u>	82	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (280)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,784,069	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,291,641	31
32	Health Care	5,867,567	32
33	General Administration	2,551,588	33
B. Capital Expense			
34	Ownership	867,333	34
C. Ancillary Expense			
35	Special Cost Centers	995,512	35
36	Provider Participation Fee	84,863	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,658,504	40
41	Income before Income Taxes (line 30 minus line 40)**	2,125,565	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,125,565	43

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

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

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

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

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	1,871	2,018	\$ 83,374	\$ 41.32	1
2	Assistant Director of Nursing	5,883	6,346	210,408	33.16	2
3	Registered Nurses	46,003	49,623	1,513,913	30.51	3
4	Licensed Practical Nurses	28,227	30,448	725,675	23.83	4
5	CNAs & Orderlies	100,180	108,268	1,364,103	12.60	5
6	CNA Trainees					6
7	Licensed Therapist	4,816	5,261	184,923	35.15	7
8	Rehab/Therapy Aides	8,578	9,371	224,238	23.93	8
9	Activity Director	8,428	9,113	115,386	12.66	9
10	Activity Assistants					10
11	Social Service Workers	5,118	5,533	84,368	15.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,832	31,112	347,593	11.17	15
16	Dishwashers					16
17	Maintenance Workers	2,044	2,206	46,830	21.23	17
18	Housekeepers	14,982	16,379	172,297	10.52	18
19	Laundry	5,627	6,094	56,001	9.19	19
20	Administrator	2,080	2,080	66,834	32.13	20
21	Assistant Administrator					21
22	Other Administrative	21,339	22,864	437,744	19.15	22
23	Office Manager					23
24	Clerical					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	1,980	2,140	30,580	14.29	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,651	1,784	22,573	12.65	33
34	TOTAL (lines 1 - 33)	287,639	310,640	\$ 5,686,840 *	\$ 18.31	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		\$		35
36	Medical Director	Monthly	47,850	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,587	10,3	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
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 55,437		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	507	8,456	10,3	52
53	TOTAL (lines 50 - 52)	507	\$ 8,456		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICHA \$3,745
- (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 \$3033
- (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? 5-10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 69,039 Line 10
- (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 _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 84,863
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 821
- (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? N/A
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. \$ _____
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.