

		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.

<p><b>I. IDPH License ID Number:</b> <u>0030015</u></p> <p><b>Facility Name:</b> <u>WESTMONT CONVALESCENT CENTER</u></p> <p><b>Address:</b> <u>6501 SOUTH CASS AVENUE</u> <u>WESTMONT</u> <u>60559</u>          Number City Zip Code</p> <p><b>County:</b> <u>DUPAGE</u></p> <p><b>Telephone Number:</b> <u>( 630 ) 960-2026</u> Fax # <u>( 630 ) 960-0480</u></p> <p><b>HFS ID Number:</b> <u>36-3376606</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>09/01/85</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u></p>	<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 checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input 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 _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>FLORA WEISS</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>GENERAL PARTNER</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u></td> <td></td> </tr> </table> <p align="right">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</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>FLORA WEISS</u>			(Title) <u>GENERAL PARTNER</u>		<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>	
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Facility Name & ID Number WESTMONT CONVALESCENT CENTER

# 0030015 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	6,567	11,894	8,286	26,747	8
9	SNF/PED					9
10	ICF	41,162	2,516	404	44,082	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,729	14,410	8,690	70,829	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.26%

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  / /

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 43 and days of care provided 7,727

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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
	<b>A. General Services</b>										
1	Dietary	300,919	24,507	7,387	332,813		332,813		332,813		1
2	Food Purchase		285,544		285,544		285,544	(12,506)	273,038		2
3	Housekeeping	319,875	56,288		376,163		376,163		376,163		3
4	Laundry	154,369	27,288	4,754	186,411		186,411		186,411		4
5	Heat and Other Utilities			302,501	302,501		302,501	410	302,911		5
6	Maintenance	77,636	36,755	30,206	144,597		144,597	1,419	146,016		6
7	Other (specify):* Security Salary	133,404		10,906	144,310		144,310	44	144,354		7
8	<b>TOTAL General Services</b>	<b>986,203</b>	<b>430,382</b>	<b>355,754</b>	<b>1,772,339</b>		<b>1,772,339</b>	<b>(10,633)</b>	<b>1,761,706</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			45,960	45,960		45,960		45,960		9
10	Nursing and Medical Records	3,022,838	168,198	42,201	3,233,237		3,233,237		3,233,237		10
10a	Therapy	215,476	3,047	1,691	220,214		220,214		220,214		10a
11	Activities	169,282	1,750	702	171,734		171,734		171,734		11
12	Social Services	115,245		1,017	116,262		116,262		116,262		12
13	CNA Training			2,341	2,341		2,341		2,341		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,522,841</b>	<b>172,995</b>	<b>93,912</b>	<b>3,789,748</b>		<b>3,789,748</b>		<b>3,789,748</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	130,933		1,078,000	1,208,933		1,208,933		1,208,933		17
18	Directors Fees										18
19	Professional Services			292,507	292,507		292,507	(5,925)	286,582		19
20	Dues, Fees, Subscriptions & Promotions			75,317	75,317		75,317	(16,315)	59,002		20
21	Clerical & General Office Expenses	185,151	25,362	23,662	234,175		234,175	(31,005)	203,170		21
22	Employee Benefits & Payroll Taxes			800,631	800,631		800,631		800,631		22
23	Inservice Training & Education			1,132	1,132		1,132		1,132		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,998	1,998		1,998		1,998		25
26	Insurance-Prop.Liab.Malpractice			222,281	222,281		222,281	91	222,372		26
27	Other (specify):*			133,720	133,720		133,720	(133,720)			27
28	<b>TOTAL General Administration</b>	<b>316,084</b>	<b>25,362</b>	<b>2,629,248</b>	<b>2,970,694</b>		<b>2,970,694</b>	<b>(186,874)</b>	<b>2,783,820</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,825,128</b>	<b>628,739</b>	<b>3,078,914</b>	<b>8,532,781</b>		<b>8,532,781</b>	<b>(197,507)</b>	<b>8,335,274</b>		<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	5,254
	REPAIRS & MAINTENANCE	2,133
		0
		7,387
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	4,754
		0
		4,754
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	67,785
	ELECTRICITY	119,861
	WATER	100,623
	CABLE TV - LOBBY	14,232
		0
		302,501
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	8,155
	PAINTING & DECORATING	1,766
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,909
	ELEVATOR MAINTENANCE & REPAIR	5,316
	OUTSIDE LABOR	4,800
	EXTERMINATING SERVICE	4,575
	FIRE SERVICE	2,685
		0
		0
		0
		0
		30,206
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	10,906
	SECURITY SERVICE	
		0
		0
		10,906
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	45,960
		45,960

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	23,625
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	10,429
	PHARMACY CONSULTANT XVIII B 39-2	3,497
	UTILIZATION REVIEW FEES XVIII B ___-2	2,100
	PHYSICIANS XVIII B ___-2	2,550
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		42,201
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	1,691
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		1,691
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	702
		0
		702
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,017
		0
		1,017
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	2,341
		2,341

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	1,078,000
<b>18</b>	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	21,347
	ADMINISTRATIVE CONSULTANTS XIX C	238,140
	PROFESSIONAL FEES XIX C	33,020
		0
		292,507
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	13,972
	EMPLOYEE WANT ADS XIX F	39,697
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	7,653
	LICENSES & PERMITS XIX F	11,652
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,343
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		75,317
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	149
	EQUIPMENT REPAIR & MAINTENANCE	4,217
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	18
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	19,278
	MESSENGER SERVICE	0
		0
		23,662

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	365,130
	UNEMPLOYMENT COMPENSATION XIX D	58,663
	WORKERS COMPENSATION INSURANC XIX D	141,060
	HOSPITALIZATION INSURANCE XIX D	103,343
	EMPLOYEE BENEFITS - OTHER XIX D	130,612
	EMPLOYEE PHYSICAL EXAMS XIX D	1,823
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		800,631
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,132
		1,132
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	1,998
		1,998
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	222,281
		222,281
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	133,720
		133,720

GRAND TOTAL COLUMN 3 OTHER

3,078,914

**WESTMONT CONVALESCENT CENTER  
SCHEDULES  
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	285,544
LESS SALES TAX	<u>(936)</u>
NET FOOD	284,608

TOTAL PATIENT CENSUS	70,829
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	212,487

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	212,487
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	212,487

NET FOOD	284,608
DIVIDE TOTAL MEALS/YEAR	<u>212,487</u>

COST PER MEAL	1.34
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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Facility Name &amp; ID Number WESTMONT CONVALESCENT CENTER

#0030015

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			126,807	126,807		126,807	175,016	301,823			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							702,711	702,711			32
33	Real Estate Taxes							114,057	114,057			33
34	Rent-Facility & Grounds			942,000	942,000		942,000	(942,000)				34
35	Rent-Equipment & Vehicles			76,375	76,375		76,375	439	76,814			35
36	Other (specify):*							(14,835)	(14,835)			36
37	<b>TOTAL Ownership</b>			1,145,182	1,145,182		1,145,182	35,388	1,180,570			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		258,484	326,019	584,503		584,503		584,503			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,713	117,713		117,713		117,713			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		258,484	443,732	702,216		702,216		702,216			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,825,128	887,223	4,667,828	10,380,179		10,380,179	(162,119)	10,218,060			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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,032)	30		9
10	Interest and Other Investment Income	(79,100)	32		10
11	Discounts, Allowances, Rebates & Refunds	(11,570)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(936)	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		20		17
18	Fines and Penalties	(18)	21		18
19	Entertainment		20		19
20	Contributions	(2,343)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(6,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(133,720)	27		24
25	Fund Raising, Advertising and Promotional	(13,972)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(31,203)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (292,894)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY					
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	130,775		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 130,775</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (162,119)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

ID# 0030015

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (153)	6	1
2	MARKETING SALARY	(31,050)	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	<b>Total</b>	(31,203)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number WESTMONT CONVALESCENT CENTER

# 0030015

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	(12,506)	0	0	0	0	0	0	0	0	0	0	(12,506)	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	410	0	0	0	0	0	0	0	0	410	5
6	Maintenance	(153)	0	1,572	0	0	0	0	0	0	0	0	1,419	6
7	Other (specify):*	0	0	44	0	0	0	0	0	0	0	0	44	7
8	<b>TOTAL General Services</b>	<b>(12,659)</b>	<b>0</b>	<b>2,026</b>	<b>0</b>	<b>(10,633)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(6,000)	0	75	0	0	0	0	0	0	0	0	(5,925)	19
20	Fees, Subscriptions & Promotions	(16,315)	0	0	0	0	0	0	0	0	0	0	(16,315)	20
21	Clerical & General Office Expenses	(31,068)	0	63	0	0	0	0	0	0	0	0	(31,005)	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	91	0	0	0	0	0	0	0	0	91	26
27	Other (specify):*	(133,720)	0	0	0	0	0	0	0	0	0	0	(133,720)	27
28	<b>TOTAL General Administration</b>	<b>(187,103)</b>	<b>0</b>	<b>229</b>	<b>0</b>	<b>(186,874)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(199,762)</b>	<b>0</b>	<b>2,255</b>	<b>0</b>	<b>(197,507)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	(14,032)	187,735	1,313	0	0	0	0	0	0	0	0	175,016	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(79,100)	779,337	2,474	0	0	0	0	0	0	0	0	702,711	32
33	Real Estate Taxes	0	112,219	1,838	0	0	0	0	0	0	0	0	114,057	33
34	Rent-Facility & Grounds	0	(942,000)	0	0	0	0	0	0	0	0	0	(942,000)	34
35	Rent-Equipment & Vehicles	0	0	439	0	0	0	0	0	0	0	0	439	35
36	Other (specify):*	0	0	(14,835)	0	0	0	0	0	0	0	0	(14,835)	36
37	<b>TOTAL Ownership</b>	<b>(93,132)</b>	<b>137,291</b>	<b>(8,771)</b>	<b>0</b>	<b>35,388</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(292,894)</b>	<b>137,291</b>	<b>(6,516)</b>	<b>0</b>	<b>(162,119)</b>	<b>45</b>							

**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		
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		ESTATE, LLC	LINCOLNWOOD	REAL ESTATE
				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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 942,000	WESTMONT REAL ESTATE, LLC	100.00%	\$	(942,000)	1
2	V	30 DEPRECIATION ( SL )				187,735	187,735	2
3	V	32 INTEREST				657,616	657,616	3
4	V	33 REAL ESTATE TAXES				112,219	112,219	4
5	V	32 MIP INSURANCE				121,721	121,721	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		\$ 942,000			\$ 1,079,291	\$ * 137,291	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		\$ 410	\$ (14,835)
16	V	5 UTILITIES				410	410
17	V	6 REPAIRS/MAINT				1,083	1,083
18	V	7 ALARM SERVICE				44	44
19	V	19 PROFESSIONAL FEES				75	75
20	V	21 OFFICE EXPENCE				63	63
21	V	26 INSURANCE				91	91
22	V	30 DEPRECIATION ( SL )				1,313	1,313
23	V	32 INTEREST				2,474	2,474
24	V	33 RE TX				1,838	1,838
25	V	35 STORAGE FEES				439	439
26	V	6 PAINTERS FEES				489	489
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			\$ 8,319	\$ * (6,516)

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

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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	\$ 539,000	17-3	1
2	DANIEL WEISS	OPERATIONS MGR	ADMINISTRAT	0.00	SEE ATTACHED			SALARY	30,000	17-1	2
3	SHIRLEY HOLT	GEN. PARTNER	ADMINISTRAT	0.16	SEE ATTACHED			MGMT FEE	539,000	17-3	3
4	RICHARD HOLT	SECURITY	SECURITY	0.00				OUTS. LAB	4,800	6-3	4
5	CAROLYN HOLT-DE LAMA	CLERK	CLERICAL	0.00				SALARY	9,600	10-1	5
6	SHARON HAUGH	BOOKKEEPER	CLERICAL	0.09	SEE ATTACHED			SALARY	23,170	21-1	6
7	JANE HOLT	MDS COMP INPUT	COMP INPUT	0.00				SALARY	12,000	10-1	7
8	SUZANE HOLD-VASKO	CLERK	IN SERV TRAIN	0.00				SALARY	25,200	10-1	8
9	AVRUM WEINFELD	CONSULTANT	COMP CONS	0.00	SEE ATTACHED			SALARY	19,200	21-1	9
10	DANIEL WEISS	ADM. CONSULT									10
11											11
12											12
13								TOTAL	\$ 1,201,970		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:

01/01/2007

Ending: 2/31/2007

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIEN DAYS	187,059	15	\$ 5,162	\$ 14,835	\$ 410	1
2	6	REPAIRS/MAINT	PATIEN DAYS	187,059	15	13,651	14,835	1,083	2
3	7	ALARM SERVICE	PATIEN DAYS	187,059	15	575	14,835	44	3
4	19	PROFESSIONAL FEES	PATIEN DAYS	187,059	15	952	14,835	75	4
5	21	OFFICE EXPENCE	PATIEN DAYS	187,059	15	831	14,835	63	5
6	26	INSURANCE	PATIEN DAYS	187,059	15	1,150	14,835	91	6
7	30	DEPRECIATION ( SL )	PATIEN DAYS	187,059	15	16,570	14,835	1,313	7
8	32	INTEREST	PATIEN DAYS	187,059	15	31,178	14,835	2,474	8
9	33	RE TX	PATIEN DAYS	187,059	15	23,213	14,835	1,838	9
10	35	STORAGE FEES	PATIEN DAYS	187,059	15	5,519	14,835	439	10
11	6	PAINTERS FEES	PATIEN DAYS	187,059	15	6,152	14,835	489	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					\$ 104,953	\$	\$ 8,319	25

Facility Name & ID Number WESTMONT CONVALESCENT CENTER

# 0030015

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	RELATED PARTY: WESTMONT REAL ESTATE, LLC						\$	\$			\$	1						
2	CAMBRIDGE REALTY		X	MORTGAGE	\$77,424.46	11/17/06	10,881,400	10,786,759	12/01/41	5.9800	647,670	2						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		348,110	336,865			9,946	3						
4	MIP INSURANCE										121,721	4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8	IME REALTY ALLOCATION										2,474	8						
9	TOTAL Facility Related				\$77,424.46		\$ 11,229,510	\$ 11,123,624			\$ 781,811	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 11,229,510	\$ 11,123,624			\$ 781,811	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 121,721      Line # 32-7

\* 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 2006 report.

\$ **92,687** 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.)

\$ **101,943** 2

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

\$ **9,256** 3

4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **102,963** 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.

\$ **112,219** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>82,311</b>	8
	2003	<b>84,637</b>	9
	2004	<b>89,708</b>	10
	2005	<b>91,769</b>	11
	2006	<b>101,943</b>	12

**FOR BHF USE ONLY**

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

13 FROM R. E. TAX STATEMENT FOR 2006 \$ 13

14 PLUS APPEAL COST FROM LINE 5 \$ 14

15 LESS REFUND FROM LINE 6 \$ 15

**THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.**

16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

**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 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 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>09-22-101-001</u>	<u>NURSING HOME</u>	\$ <u>94,629.68</u>	\$ <u>94,629.68</u>
2. <u>09-22-101-002</u>	<u>NURSING HOME</u>	\$ <u>4,692.92</u>	\$ <u>4,692.92</u>
3. <u>09-22-101-003</u>	<u>NURSING HOME</u>	\$ <u>2,620.70</u>	\$ <u>2,620.70</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>101,943.30</u>	\$ <u>101,943.30</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 WESTMONT CONVALESCENT CENTER

# 0030015

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Rows include 1, 2 PARKING LOT, and 3 TOTALS.

Facility Name &amp; ID Number WESTMONT CONVALESCENT CENTER

# 0030015

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## 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	\$	\$ 1,634,272	4
5										5
6										6
7										7
8	IME REALTY ALLOC				1,262		1,262			8
	Improvement Type**									
9	FLOORING		1986	41,641		19			41,641	9
10	ROOF & WATER LINE		1987	31,143	989	20	789	(200)	31,143	10
11	IMPROVEMENTS		1988	44,614	1,416	31.5	1,416		27,607	11
12	IMPROVEMENTS		1989	40,935	1,299	31.5	1,299		23,973	12
13	DRIVEWAY		1989	17,137		15	247	247	17,137	13
14	IMPROVEMENTS		1990	37,367	1,186	31.5	1,186		20,704	14
15	IMPROVEMENTS		1991	45,002	1,428	31.5	1,428		23,323	15
16	IMPROVEMENTS		1992	49,649	1,577	31.5	1,577		24,350	16
17	ROOF TOP A/C UNITS		1993	9,100	289	31.5	289		4,311	17
18	IMPROVEMENTS		1993	53,243	1,366	39	1,366		19,657	18
19	IMPROVEMENTS		1994	31,230	801	39	801		10,930	19
20	FLOOR COVERING		1995	795	20	15	53	33	689	20
21	HAND RAIL		1995	2,249	58	39	58		747	21
22	FLOOR TILES		1995	5,471	140	39	140		1,768	22
23	WINDOW A/C UNITS		1995	14,146	363	39	363		4,521	23
24	ARJO TUB & ATTACHED PLUMBING		1995	12,056	309	39	309		3,876	24
25	ALARM		1995	1,337	34	39	34		424	25
26	LAUNDRY BUILDING		1995	35,000	897	39	897		11,026	26
27	ROOF		1995	5,520	142	39	142		1,745	27
28	WINDOWS		1995	9,478	243	39	243		2,967	28
29	DOOR EDGE & DOOR FRAME		1996	2,099	54	39	54		646	29
30	LAUNDRY BUILDING		1996	175,187	4,491	39	4,491		51,844	30
31	AIR COOLERS		1996	6,642	171	39	171		1,964	31
32	RACING CAGE		1996	3,987	102	39	102		1,177	32
33	HAND RAIL		1996	1,156	30	39	30		341	33
34	WINDOWS		1996	11,496	295	39	295		3,356	34
35	TACK ROOM		1996	2,139	55	39	55		621	35
36	NEW CONFERENCE ROOM - TILE		1997	2,938	76	39	76		782	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number WESTMONT CONVALESCENT CENTER

# 0030015

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## 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		\$ 391	37
38	NURSING STATION - 2ND FLOOR	1997	5,397	138	39	138		1,398	38
39	WINDON-NURSING OFFICE	1997	1,382	35	39	35		354	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107	28	39	28		307	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927	126	39	126		1,224	41
42	THE PARKING LOT	1998	42,711	2,990	15	2,990		26,718	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223	160	39	160		1,583	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715	326	39	326		2,975	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473	269	39	269		2,410	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452	89	39	89		775	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495	38	39	38		331	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877	74	39	74		638	48
49	REMODELING F WING SHOWER ROOM	1999	8,988	230	39	230		1,965	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370	61	39	61		516	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760	71	39	71		583	51
52	WATER HEATER - DIETARY	1999	2,931	75	39	75		609	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073	79	39	79		642	53
54	TILE - DINING ROOM	1999	1,212	31	39	31		252	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200	185	39	185		1,503	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738	70	39	70		563	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265	249	20	163	(86)	1,304	57
58	WATER HEATER - DIETARY	2000	3,573	130	27.5	130		948	58
59	GENERAL CONSTRUCTION	2000	27,448	998	27.5	998		7,194	59
60	ROOF REPAIR	2000	4,200	153	27.5	153		1,103	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910	106	27.5	106		746	61
62	NEW A/C UNIT ROOF TOP	2000	4,694	171	27.5	171		1,204	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523	6,170	20	4,026	(2,144)	32,208	63
64	SHOWER ROOM RENOVATIONS	2001	30,586	1,112	27.5	1,112		7,553	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341	3,903	27.5	3,903		24,882	65
66	WATER HEATER - LAUNDRY	2001	9,108	331	27.5	331		2,000	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464	453	27.5	453		2,737	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861		20	13,543	13,543	94,801	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114	1,117	20	1,456	339	8,736	69
70	TOTAL (lines 4 thru 69)		\$ 6,386,654	\$ 166,850		\$ 178,582	\$ 11,732	\$ 2,198,695	70

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

Facility Name &amp; ID Number WESTMONT CONVALESCENT CENTER

# 0030015

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,386,654	\$ 166,850		\$ 178,582	\$ 11,732	\$ 2,198,695	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997	630	15	600	(30)	3,180	2
3	SHOWER ROOM	2002	30,924	1,125	27.5	1,125		5,859	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010	328	27.5	328		1,654	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891	541	27.5	541		2,728	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056	3,493	20	2,003	(1,490)	12,018	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499	1,003	20	575	(428)	3,450	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767	464	27.5	464		2,069	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152	1,133	27.5	1,133		5,051	9
10	THERAPY ROOM -FLOORING	2003	87,509	3,182	27.5	3,182		14,186	10
11	CONFERENCE ROOM-FLOORING	2003	2,073	76	27.5	76		339	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421	270	27.5	270		934	12
13	TONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825	3,266	27.5	3,266		10,751	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925	1,852	27.5	1,852		5,942	14
15	RESIDENT ROOMS-FLOORING	2005	9,821	357	27.5	357		967	15
16	INSTALL CABLING SYSTEM	2005	46,771	1,701	27.5	1,701		4,465	16
17	INSTALL TWO AUTOMATIC SLIDING DOOR	2005	28,000	1,018	27.5	1,018		2,078	17
18	1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE	2005	58,286	11,191	20	2,914	(8,277)	8,742	18
19	INSTALL DOORS - F WING, RESIDENT ROOMS	2006	4,260	155	27.5	155		291	19
20	WALLCOVERING, FLOORING - 1ST FLOOR CORRID	2006	63,838	2,321	27.5	2,321		4,158	20
21	AIR CONDITIONS	2006	7,968	289	27.5	289		429	21
22	REPLACEMENT WALK - IN FREEZER DOOR	2006	4,652	169	27.5	169		261	22
23	REPLACEMENT OF KITCHEN TILES	2007	13,200	380	27.5	380		380	23
24									24
25	WESTMONT REAL ESTATE, LLC								25
26	NEW PARKING LOT	2007	209,876	3,498	15	3,498		3,498	26
27	RESIDENT ROOMS-FLOORING, WINGS B,C,D,E,F	2007	235,801	3,931	27.5	3,931		3,931	27
28	RESIDENT ROOMS-PAINTING, WINGS B,C,D,E,F	2007	84,360	16,872	5	16,872		16,872	28
29	INSTALL NEW FIRE DOORS IN EXIST. FRAME E WING	2007	3,108	52	27.5	52		52	29
30	TUCKPOINTING, AIR CONDITIONS, WATER HEATER	2007	18,594	3,719	5	3,719		3,719	30
31	INSTALLATION OF RAILLING ON EXTERIROR STAIRS	2007	6,407	106	27.5	106		106	31
32	REPLACE EXISTING RECEIVING DR/FRAME/HARDWARE	2007	3,108	52	27.5	52		52	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,581,753	\$ 230,024		\$ 231,531	\$ 1,507	\$ 2,316,857	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	\$ 643,944	\$ 53,010	\$ 38,233	\$ (14,777)		\$ 407,290	71
72	Current Year Purchases	5,079	1,016	254	(762)		254	72
73	Fully Depreciated Assets	447,982					447,982	73
74	RELATED PARTY		31,805	31,805				74
75	TOTALS	\$ 1,097,005	\$ 85,831	\$ 70,292	\$ (15,539)		\$ 855,526	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)	\$ 9,438,584	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 315,855	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 301,823	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (14,032)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,172,383	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: \$ 31,437 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	2007 BMW	\$ #####	\$ 14,026	17
18	ADMINISTRATIVE	2007 LAND ROVER	#####	15,445	18
19	ADMINISTRATIVE	2005 TOYOTA AVALON	575.00	6,900	19
20	FACILITY	2007 FORD ECONOLINE	745.00	8,567	20
21	TOTAL		\$ #####	\$ 44,938	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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$ 685	\$	\$ 685
2	Books and Supplies			\$ 1,656	1,656
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 685	\$ 1,656	\$ 2,341
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	685		

**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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>5</b>

- (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	\$		\$ 134,729	\$		\$ 134,729	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,364			10,364	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			180,926			180,926	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				230,750		230,750	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES, TUBE FEEDING Other (specify): <b>RADIOLOGY, LAB</b>	39-2 39-2					14,543 13,191		14,543 13,191	13
14	<b>TOTAL</b>			\$		\$ 326,019	\$ 258,484		\$ 584,503	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 &amp; ID Number WESTMONT CONVALESCENT CENTER

# 0030015

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 985,554	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000 )	1,560,578		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	298,075		6
7	Other Prepaid Expenses	77,996		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,922,203	\$	10
	<b>B. Long-Term Assets</b>			
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	2,038,198		15
16	Equipment, at Historical Cost	1,097,005		16
17	Accumulated Depreciation (book methods)	(1,979,222)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,155,981	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,078,184	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 145,423	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	167,600		30
31	Accrued Taxes Payable (excluding real estate taxes)	67,745		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 380,768	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>DUE TO WESTMONT REALTY,LLC</u>	5,175,960		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 5,175,960	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 5,556,728	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,478,544)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,078,184	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,324,436)	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,324,432)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	775,763	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	(929,875)	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)	\$ (154,112)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,478,544)	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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 10,762,457	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,762,457	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	232,028	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 232,028	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	9,587	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 9,587	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	79,100	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 79,100	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>COMPUTER INCOME</b>	61,200	28
28a	<b>DISCOUNTS EARNED</b>	11,570	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 72,770	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,155,942	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,772,339	31
32	Health Care	3,789,748	32
33	General Administration	2,970,694	33
	<b>B. Capital Expense</b>		
34	Ownership	1,145,182	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	584,503	35
36	Provider Participation Fee	117,713	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,380,179	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	775,763	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 775,763	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: **01/01/2007**

Ending:

**12/31/2007**

**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	3,433	3,884	\$ 91,667	\$ 23.60	1
2	Assistant Director of Nursing	2,444	2,767	65,273	23.59	2
3	Registered Nurses	36,777	39,835	1,117,162	28.04	3
4	Licensed Practical Nurses	8,044	8,517	204,555	24.02	4
5	CNAs & Orderlies	128,609	134,185	1,512,314	11.27	5
6	CNA Trainees					6
7	Licensed Therapist	2,110	2,316	70,658	30.51	7
8	Rehab/Therapy Aides	9,038	9,961	144,818	14.54	8
9	Activity Director	4,143	4,556	71,639	15.72	9
10	Activity Assistants	11,185	11,572	97,643	8.44	10
11	Social Service Workers	6,262	6,706	115,245	17.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,263	32,413	300,919	9.28	15
16	Dishwashers					16
17	Maintenance Workers	5,550	6,030	77,636	12.87	17
18	Housekeepers	39,916	41,383	319,875	7.73	18
19	Laundry	18,998	19,868	154,369	7.77	19
20	Administrator	1,485	1,602	75,933	47.40	20
21	Assistant Administrator	651	651	25,000	38.40	21
22	Other Administrative	1,040	1,040	30,000	28.85	22
23	Office Manager					23
24	Clerical	17,049	17,967	185,151	10.31	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	2,101	1,982	31,867	16.08	31
32	Other Health Care(specify)					32
33	Other(specify) <u>SECURITY</u>	4,803	4,843	133,404	27.55	33
34	TOTAL (lines 1 - 33)	332,901	352,078	\$ 4,825,128 *	\$ 13.70	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	\$ 5,254	1-3	35
36	Medical Director	Monthly	45,960	9-3	36
37	Medical Records Consultant	Monthly	10,429	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly	3,497	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	12	702	11-3	44
45	Social Service Consultant	17	1,017	12-3	45
46	Other(specify) <u>Rehabilitation</u>	29	1,691	10-3	46
47	<u>Utilization review fees</u>	Monthly	2,100	10-3	47
48	<u>Physicians</u>	Monthly	2,550	10-3	48
49	TOTAL (lines 35 - 48)	58	\$ 73,200		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	159	\$ 5,795	10-3	50
51	Licensed Practical Nurses	515	17,830	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	674	\$ 23,625		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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1	<b>PAIN/DECORATING</b>	<b>7/04</b>	<b>\$ 2,834</b>	<b>3 YRS</b>	<b>\$ 472</b>	<b>\$ 945</b>	<b>\$ 945</b>	<b>\$ 472</b>												
2	<b>PAIN/DECORATING</b>	<b>7/05</b>	<b>1,544</b>	<b>3 YRS</b>		<b>258</b>	<b>514</b>	<b>514</b>	<b>258</b>											
3	<b>PAIN/DECORATING</b>	<b>7/06</b>	<b>1,882</b>	<b>3 YRS</b>			<b>314</b>	<b>627</b>	<b>627</b>	<b>314</b>										
4																				
5																				
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18																				
19																				
20	<b>TOTALS</b>		<b>\$ 6,260</b>		<b>\$ 472</b>	<b>\$ 1,203</b>	<b>\$ 1,773</b>	<b>\$ 1,613</b>	<b>\$ 885</b>	<b>\$ 314</b>										

Facility Name &amp; ID Number WESTMONT CONVALESCENT CENTER

# 0030015

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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 ON LONG TERM CARE \$7583
- (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. \$ 36,001 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 09/01/85
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees