

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,162	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,690	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	6,268	1,948	10,681	18,897	8
9	SNF/PED					9
10	ICF	41,920	9,150	314	51,384	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,188	11,098	10,995	70,281	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.31%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 09/03/08

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/03/08 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 10,681

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CEN # 0050120 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	296,841	26,017	6,060	328,918		328,918		328,918		1
2	Food Purchase		304,411		304,411		304,411	(1,271)	303,140		2
3	Housekeeping	376,068	56,911		432,979		432,979		432,979		3
4	Laundry	120,530	34,723	6,870	162,123		162,123		162,123		4
5	Heat and Other Utilities			291,844	291,844		291,844	442	292,286		5
6	Maintenance	82,594	57,623	38,622	178,839		178,839	1,351	180,190		6
7	Other (specify):* Security Salary	85,427		12,776	98,203		98,203	24	98,227		7
8	TOTAL General Services	961,460	479,685	356,172	1,797,317		1,797,317	546	1,797,863		8
	B. Health Care and Programs										
9	Medical Director			45,020	45,020		45,020		45,020		9
10	Nursing and Medical Records	3,182,898	228,940	81,965	3,493,803		3,493,803		3,493,803		10
10a	Therapy	185,475	6,870		192,345		192,345		192,345		10a
11	Activities	160,868	1,826	15,792	178,486		178,486		178,486		11
12	Social Services	128,143		1,610	129,753		129,753		129,753		12
13	CNA Training			6,843	6,843		6,843		6,843		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,657,384	237,636	151,230	4,046,250		4,046,250		4,046,250		16
	C. General Administration										
17	Administrative	164,568		1,056,000	1,220,568		1,220,568		1,220,568		17
18	Directors Fees										18
19	Professional Services			254,686	254,686		254,686	(2,542)	252,144		19
20	Dues, Fees, Subscriptions & Promotions			107,442	107,442		107,442	(29,154)	78,288		20
21	Clerical & General Office Expenses	271,734	35,100	31,975	338,809		338,809	(70,998)	267,811		21
22	Employee Benefits & Payroll Taxes			802,219	802,219		802,219		802,219		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,242	2,242		2,242		2,242		24
25	Other Admin. Staff Transportation			3,872	3,872		3,872	(2,100)	1,772		25
26	Insurance-Prop.Liab.Malpractice			225,558	225,558		225,558	100	225,658		26
27	Other (specify):*			53,573	53,573		53,573	(53,573)			27
28	TOTAL General Administration	436,302	35,100	2,537,567	3,008,969		3,008,969	(158,267)	2,850,702		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,055,146	752,421	3,044,969	8,852,536		8,852,536	(157,721)	8,694,815		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	4,620
	REPAIRS & MAINTENANCE	1,440
		0
		6,060
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	6,870
		0
		6,870
5	HEAT & OTHER UTILITIES	
	GAS HEAT	86,654
	ELECTRICITY	109,131
	WATER	96,059
	CABLE TV - LOBBY	0
		0
		291,844
6	MAINTENANCE	
	GROUNDS MAINTENANCE	17,951
	PAINTING & DECORATING	1,511
	BUILDING REPAIRS	
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,721
	ELEVATOR MAINTENANCE & REPAIR	6,788
	OUTSIDE LABOR	2,100
	EXTERMINATING SERVICE	4,575
	FIRE SERVICE	3,976
		0
		0
		0
		0
		38,622
7	OTHER	
	SCAVENGER	12,776
	SECURITY SERVICE	0
		0
		0
		12,776
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	45,020
		45,020

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	61,618
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	425
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	10,622
	PHARMACY CONSULTANT XVIII B 39-2	3,545
	UTILIZATION REVIEW FEES XVIII B ___-2	1,800
	PHYSICIANS XVIII B ___-2	3,955
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		81,965
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	15,081
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	711
		15,792
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,610
		0
		1,610
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	6,843
		6,843

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	1,056,000
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	34,683
	ADMINISTRATIVE CONSULTANTS XIX C	158,760
	PROFESSIONAL FEES XIX C	61,243
		0
		254,686
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,666
	EMPLOYEE WANT ADS XIX F	40,814
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	932
	LICENSES & PERMITS XIX F	36,542
	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	13,488
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		107,442
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	319
	EQUIPMENT REPAIR & MAINTENANCE	6,803
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	24,853
	MESSENGER SERVICE	0
		0
		31,975

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	382,713
	UNEMPLOYMENT COMPENSATION XIX D	56,071
	WORKERS COMPENSATION INSURANC XIX D	154,895
	HOSPITALIZATION INSURANCE XIX D	99,053
	EMPLOYEE BENEFITS - OTHER XIX D	109,047
	EMPLOYEE PHYSICAL EXAMS XIX D	440
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		802,219
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,242
	TRAVEL XIX G	0
		2,242
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,872
		3,872
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	225,558
		225,558
27	OTHER	
	BAD DEBTS VI 24	53,573
		53,573

GRAND TOTAL COLUMN 3 OTHER

3,044,969

WESTMONT NURSING AND REHAB CENTER
SCHEDULES
12/31/2008

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

TOTAL FOOD PURCHASE	304,411
LESS SALES TAX	<u>(1,271)</u>
NET FOOD	303,140

TOTAL PATIENT CENSUS	70,281
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	210,843

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	210,843
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	210,843

NET FOOD	303,140
DIVIDE TOTAL MEALS/YEAR	<u>210,843</u>

COST PER MEAL	1.44
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			59,233	59,233		59,233	323,793	383,026			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			300,482	300,482		300,482	279,500	579,982			32
33	Real Estate Taxes							107,012	107,012			33
34	Rent-Facility & Grounds			942,000	942,000		942,000	(942,000)				34
35	Rent-Equipment & Vehicles			51,628	51,628		51,628	468	52,096			35
36	Other (specify):* OFFICE RENT			14,835	14,835		14,835	(14,835)				36
37	TOTAL Ownership			1,368,178	1,368,178		1,368,178	(246,062)	1,122,116			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		271,810	756,767	1,028,577		1,028,577		1,028,577			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,036	118,036		118,036		118,036			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		271,810	874,803	1,146,613		1,146,613		1,146,613			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,055,146	1,024,231	5,287,950	11,367,327		11,367,327	(403,783)	10,963,544			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	66,858	30		9
10	Interest and Other Investment Income	(130,417)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,271)	2		13
14	Non-Care Related Interest	(298,040)	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		21		18
19	Entertainment		20		19
20	Contributions	(13,488)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,711)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,573)	27		24
25	Fund Raising, Advertising and Promotional	(15,666)	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 <u>SEE PAGE 5A</u>	(73,764)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (522,072)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	118,289		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 118,289		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (403,783)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
 WESTMONT NURSING AND REHAB CENTER

ID# 0050120

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (626)	6	1
2	MARKETING SALARY	(71,038)	21	2
3	MARKETIG-STAFF TRANSPORTATION	(2,100)	25	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	(73,764)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(1,271)	0	0	0	0	0	0	0	0	0	0	(1,271)	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	442	0	0	0	0	0	0	0	0	442	5
6	Maintenance	(626)	0	1,977	0	0	0	0	0	0	0	0	1,351	6
7	Other (specify):*	0	0	24	0	0	0	0	0	0	0	0	24	7
8	TOTAL General Services	(1,897)	0	2,443	0	546	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,711)	0	169	0	0	0	0	0	0	0	0	(2,542)	19
20	Fees, Subscriptions & Promotions	(29,154)	0	0	0	0	0	0	0	0	0	0	(29,154)	20
21	Clerical & General Office Expenses	(71,038)	0	40	0	0	0	0	0	0	0	0	(70,998)	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	(2,100)	0	0	0	0	0	0	0	0	0	0	(2,100)	25
26	Insurance-Prop.Liab.Malpractice	0	0	100	0	0	0	0	0	0	0	0	100	26
27	Other (specify):*	(53,573)	0	0	0	0	0	0	0	0	0	0	(53,573)	27
28	TOTAL General Administration	(158,576)	0	309	0	(158,267)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(160,473)	0	2,752	0	(157,721)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	66,858	255,560	1,375	0	0	0	0	0	0	0	0	323,793	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(428,457)	705,433	2,524	0	0	0	0	0	0	0	0	279,500	32
33	Real Estate Taxes	0	105,094	1,918	0	0	0	0	0	0	0	0	107,012	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	468	0	0	0	0	0	0	0	0	468	35
36	Other (specify):*	0	0	(14,835)	0	0	0	0	0	0	0	0	(14,835)	36
37	TOTAL Ownership	(361,599)	124,087	(8,550)	0	(246,062)	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)	(522,072)	124,087	(5,798)	0	(403,783)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				WESTMONT REAL		
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)				255,560	255,560	2
3	V	32 INTEREST				651,769	651,769	3
4	V	33 REAL ESTATE TAXES				105,094	105,094	4
5	V	32 MIP INSURANCE				53,664	53,664	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			\$ 1,066,087	\$ * 124,087	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 14,835	IME REALTY CORP		\$	(14,835)
16	V	5 UTILITIES				442	442
17	V	6 PAINTERS FEES				974	974
18	V	6 REPAIRS/MAINT				1,003	1,003
19	V	7 ALARM SERVICE				24	24
20	V	19 ACCOUNTING FEES				169	169
21	V	21 OFFICE EXPENSE				40	40
22	V	26 INSURANCE				100	100
23	V	30 DEPRECIATION (SL)				1,375	1,375
24	V	32 INTEREST				2,524	2,524
25	V	33 RE TAX				1,918	1,918
26	V	35 STORAGE FEES				468	468
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			\$ 9,037	\$ * (5,798)

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CEI # 0050120 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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. PARTNERS	ADMINISTRAT.	0.00	SEE ATTACHED			MGMT FEE	\$ 415,500	17-3	1
2	SHIRLEY HOLT	GEN. PARTNERS	ADMINISTRAT.	0.00	SCHEDULE			MGMT FEE	415,500	17-3	2
3	DANIEL WEISS	OPERAT.MANAGE	ADMINISTRAT.	0.00				SALARY	20,000	17-1	3
4	RICHARD HOLD	SECURITY	SECURITY	0.00				OUTSIDE LAB	2,100	6-3	4
5	COROLYN HOLT-DELAMA	MARKETIG	MARKETING	0.00				SALARY	6,400	21-1	5
6	SHARON HAUGH	BOOKKEEPER	ACCT. RECIEV.					SALARY	15,447	21-1	6
7	JANE HOLT	MDS COMP INPUT	COMP INPUT	0.00				SALARY	8,000	10-1	7
8	SUZANE HOLT-VASKO	CLERK	IN SERV TRAIN	0.00				SALARY	16,800	10-1	8
9	AVRUM WEINFELD	CONSULTANT	COMP CONS	0.00				SALARY	12,800	21-1	9
10											10
11	DANIEL WEISS	GEN. PARTNERS	ADMINISTRAT.	40.00				MGMT FEE	112,500	17-3	11
12	AVRUM WEINFELD	GEN. PARTNERS	ADMINISTRAT.	40.00				MGMT FEE	112,500	17-3	12
13								TOTAL	\$ 1,137,547		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 NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	187,059	14	\$ 5,588	\$ 14,835	\$ 442	1
2	6	PAINTERS FEES	INCOME	187,059	14	12,303	14,835	974	2
3	6	REPAIRS/MAINT	INCOME	187,059	14	12,671	14,835	1,003	3
4	7	ALARM SERVICE	INCOME	187,059	14	301	14,835	24	4
5	19	ACCOUNTING FEES	INCOME	187,059	14	2,135	14,835	169	5
6	21	OFFICE EXPENSE	INCOME	187,059	14	489	14,835	40	6
7	26	INSURANCE	INCOME	187,059	14	1,275	14,835	100	7
8	30	DEPRECIATION (SL)	INCOME	187,059	14	17,336	14,835	1,375	8
9	32	INTEREST	INCOME	187,059	14	31,829	14,835	2,524	9
10	33	RE TAX	INCOME	187,059	14	24,171	14,835	1,918	10
11	35	STORAGE FEES	INCOME	187,059	14	5,882	14,835	468	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					\$ 113,980	\$	\$ 9,037	25

Facility Name & ID Number

WESTMONT NURSING AND REHAB CEN

0050120

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	RELATED PARTY: WESTMONT REAL ESTATE, LLC						\$	\$			\$	1						
2	CAMBRIDGE REALTY		X	MORTGAGE	\$77,424.46	11/17/06	10,881,400	10,686,301	12/01/41	5.9800	641,823	2						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		347,110	326,919			9,946	3						
4	MIP INSURANCE										53,664	4						
5												5						
	Working Capital																	
6	MB FINANCIAL		X	WORKING CAPITAL	DEMAND	09/08	2,000,000	750,000		PRIME+	2,442	6						
7												7						
8	IME REALTY ALLOCATION										2,524	8						
9	TOTAL Facility Related				\$77,424.46		\$ 13,228,510	\$ 11,763,220			\$ 710,399	9						
	B. Non-Facility Related*																	
10	BRICKYRD BANK		X	GOODWILL	\$29,590.38	09/08	1,500,000	1,415,166	09/13	6.7500	33,527	10						
11	GOODWILL		X	GOODWILL	\$42,088.99	09/08	7,500,000	1,500,000	09/33	6.0000	264,513	11						
12												12						
13												13						
14	TOTAL Non-Facility Related				\$71,679.37		\$ 9,000,000	\$ 2,915,166			\$ 298,040	14						
15	TOTALS (line 9+line14)						\$ 22,228,510	\$ 14,678,386			\$ 1,008,439	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 53,664 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 2007 report.		\$	102,963	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.)		\$	103,511	2
3. Under or (over) accrual (line 2 minus line 1).		\$	548	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	104,546	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.		\$	105,094	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	84,637	8
	2004	89,708	9
	2005	91,769	10
	2006	101,943	11
	2007	103,511	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTMONT NURSING AND REHAB CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0050120

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 2007 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 2007.

(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>94,986.08</u>	\$ <u>94,986.08</u>
2. <u>09-22-101-002</u>	<u>NURSING HOME</u>	\$ <u>4,710.60</u>	\$ <u>4,710.60</u>
3. <u>09-22-101-003</u>	<u>NURSING HOME</u>	\$ <u>3,814.18</u>	\$ <u>3,814.18</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>103,510.86</u>	\$ <u>103,510.86</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>1995</u>	<u>\$ 349,103</u>	<u>1</u>
2	<u>PARKING LOT</u>		<u>2006</u>	<u>410,723</u>	<u>2</u>
3	TOTALS			\$ 759,826	3

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$	\$ 1,762,023	4
5										5
6										6
7										7
8	TIME REALTY ALLOCATION				1,323		1,323			8
	Improvement Type**									
9	FLOORING		1986	41,641		19			41,641	9
10	ROOF & WATER LINE		1987	31,143	659	20	789	130	31,932	10
11	IMPROVEMENTS		1988	44,614	944	31.5	1,416	472	29,023	11
12	IMPROVEMENTS		1989	40,935	865	31.5	1,299	434	25,272	12
13	DRIVEWAY		1989	17,137		15	247	247	17,384	13
14	IMPROVEMENTS		1990	37,367	791	31.5	1,186	395	21,890	14
15	IMPROVEMENTS		1991	45,002	953	31.5	1,428	475	24,751	15
16	IMPROVEMENTS		1992	49,649	1,051	31.5	1,577	526	25,927	16
17	ROOF TOP A/C UNITS		1993	9,100	193	31.5	289	96	4,600	17
18	IMPROVEMENTS		1993	53,243	911	39	1,366	455	21,023	18
19	IMPROVEMENTS		1994	31,230	534	39	801	267	11,731	19
20	FLOOR COVERING		1995	795	13	15	53	40	742	20
21	HAND RAIL		1995	2,249	39	39	58	19	805	21
22	FLOOR TILES		1995	5,471	93	39	140	47	1,908	22
23	WINDOW A/C UNITS		1995	14,146	242	39	363	121	4,884	23
24	ARJO TUB & ATTACHED PLUMBING		1995	12,056	206	39	309	103	4,185	24
25	ALARM		1995	1,337	23	39	34	11	458	25
26	LAUNDRY BUILDING		1995	35,000	598	39	897	299	11,923	26
27	ROOF		1995	5,520	95	39	142	47	1,887	27
28	WINDOWS		1995	9,478	162	39	243	81	3,210	28
29	DOOR EDGE & DOOR FRAME		1996	2,099	36	39	54	18	700	29
30	LAUNDRY BUILDING		1996	175,187	2,993	39	4,491	1,498	56,335	30
31	AIR COOLERS		1996	6,642	114	39	171	57	2,135	31
32	RACING CAGE		1996	3,987	68	39	102	34	1,279	32
33	HAND RAIL		1996	1,156	20	39	30	10	371	33
34	WINDOWS		1996	11,496	197	39	295	98	3,651	34
35	TACK ROOM		1996	2,139	37	39	55	18	676	35
36			1997	2,938	51	39	76	25	858	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 & ID Number WESTMONT NURSING AND REHAB CENTER

0050120

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$ 25	39	\$ 38	\$ 13	\$ 429	37
38	NURSING STATION - 2ND FLOOR	1997	5,397	91	39	138	47	1,536	38
39	WINDON-NURSING OFFICE	1997	1,382	24	39	35	11	389	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107	19	39	28	9	335	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927	84	39	126	42	1,350	41
42	THE PARKING LOT	1998	42,711	1,708	15	2,990	1,282	29,708	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223	107	39	160	53	1,743	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715	218	39	326	108	3,301	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473	179	39	269	90	2,679	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452	60	39	89	29	864	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495	25	39	38	13	369	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877	49	39	74	25	712	48
49	REMODELING F WING SHOWER ROOM	1999	8,988	153	39	230	77	2,195	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370	41	39	61	20	577	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760	47	39	71	24	654	51
52	WATER HEATER - DIETARY	1999	2,931	50	39	75	25	684	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073	53	39	79	26	721	53
54	TILE - DINING ROOM	1999	1,212	21	39	31	10	283	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200	123	39	185	62	1,688	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738	47	39	70	23	633	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265		20	163	163	1,467	57
58	WATER HEATER - DIETARY	2000	3,573	87	27.5	130	43	1,078	58
59	GENERAL CONSTRUCTION	2000	27,448	665	27.5	998	333	8,192	59
60	ROOF REPAIR	2000	4,200	102	27.5	153	51	1,256	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910	71	27.5	106	35	852	61
62	NEW A/C UNIT ROOF TOP	2000	4,694	114	27.5	171	57	1,375	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523		20	4,026	4,026	36,234	63
64	SHOWER ROOM RENOVATIONS	2001	30,586	741	27.5	1,112	371	8,665	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341	2,602	27.5	3,903	1,301	28,785	65
66	WATER HEATER - LAUNDRY	2001	9,108	221	27.5	331	110	2,331	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464	302	27.5	453	151	3,190	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861		20	13,543	13,543	108,344	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114		20	1,456	1,456	10,192	69
70	TOTAL (lines 4 thru 69)		\$ 6,386,654	\$ 148,991		\$ 178,643	\$ 29,652	\$ 2,376,015	70

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,386,654	\$ 148,991		\$ 178,643	\$ 29,652	\$ 2,376,015	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997	420	15	600	180	3,780	2
3	SHOWER ROOM	2002	30,924	750	27.5	1,125	375	6,984	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010	219	27.5	328	109	1,982	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891	361	27.5	541	180	3,269	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056		20	2,003	2,003	14,021	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499		20	575	575	4,025	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767	310	27.5	464	154	2,533	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152	755	27.5	1,133	378	6,184	9
10	THERAPY ROOM -FLOORING	2003	87,509	2,120	27.5	3,182	1,062	17,368	10
11	CONFERENCE ROOM-FLOORING	2003	2,073	51	27.5	76	25	415	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421	180	27.5	270	90	1,204	12
13	TONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825	2,177	27.5	3,266	1,089	14,017	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925	1,234	27.5	1,852	618	7,794	14
15	RESIDENT ROOMS-FLOORING	2005	9,821	238	27.5	357	119	1,324	15
16	INSTALL CABLING SYSTEM	2005	46,771	1,134	27.5	1,701	567	6,166	16
17	INSTALL TWO AUTOMATIC SLIDING DOOR	2005	28,000	679	27.5	1,018	339	3,096	17
18	1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE	2005	58,286	4,476	20	2,914	(1,562)	11,656	18
19	INSTALL DOORS - F WING, RESIDENT ROOMS	2006	4,260	103	27.5	155	52	446	19
20	WALLCOVERING, FLOORING - 1ST FLOOR CORRID	2006	63,838	1,547	27.5	2,321	774	6,479	20
21	AIR CONDITIONS	2006	7,968	193	27.5	289	96	718	21
22	REPLACEMENT WALK - IN FREEZER DOOR	2006	4,652	113	27.5	169	56	430	22
23	REPLACEMENT OF KITCHEN TILES	2007	13,200	320	27.5	380	60	760	23
24									24
25	WESTMONT REAL ESTATE, LLC								25
26	NEW PARKING LOT	2007	206,876	13,792	15	13,792		17,290	26
27	RESIDENT ROOMS-FLOORING, WINGS B,C,D,E,F	2007	235,801	8,574	27.5	8,574		12,505	27
28	RESIDENT ROOMS-PAINTING, WINGS B,C,D,E,F	2007	84,360	26,996	5	26,996		43,868	28
29	INSTALL NEW FIRE DOORS IN EXIST. FRAME E WING	2007	3,108	113	27.5	113		165	29
30	TUCKPOINTING, AIR CONDITIONS, WATER HEATER	2007	18,594	5,950	5	5,950		9,669	30
31	INSTALLATION OF RAILLING ON EXTERIROR STAIRS	2007	6,407	233	27.5	233		339	31
32	REPLACE EXISTING RECEIVING DR/FRAME/HARDWARE	2007	3,108	113	27.5	113		165	32
33	AIR CONDITIONS	2008	12,661	7,597	5	7,597		7,597	33
34	TOTAL (lines 1 thru 33)		\$ 7,591,414	\$ 229,739		\$ 266,730	\$ 36,991	\$ 2,582,264	34

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	
1		\$ 7,591,414	\$ 229,739		\$ 266,730	\$ 36,991	\$ 2,582,264	1
2	2008	3,640	60	27.5	60		60	2
3	2008	2,869	48	27.5	48		48	3
4	2008	2,948	50	27.5	50		50	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	TOTAL (lines 1 thru 33)	\$ 7,600,871	\$ 229,897		\$ 266,888	\$ 36,991	\$ 2,582,422	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	\$ 562,468	\$ 21,936	\$ 51,803	\$ 29,867	3-10	\$ 372,792	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	534,537					534,537	73
74	RELATED PARTY SL DEPRECIATION		64,335	64,335				74
75	TOTALS	\$ 1,097,005	\$ 86,271	\$ 116,138	\$ 29,867		\$ 907,329	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)	\$ 9,457,702	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 316,168	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 383,026	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 66,858	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,489,751	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: \$ 17,511 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	\$ #####	\$ 9,442	17
18	ADMINISTRATIVE	2007 LAND ROVER	#####	10,200	18
19	ADMINISTRATIVE	2005 TOYOTA AVALON	575.00	5,175	19
20	FACILITY	2007 FORD ECONOLINE	775.00	9,300	20
21	TOTAL		\$ #####	\$ 34,117	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. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

* 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>130</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" 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	\$	\$	\$	\$
2	Books and Supplies			1,778	1,778
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		5,065		5,065
9	TOTALS	\$	\$ 5,065	\$ 1,778	\$ 6,843
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,065		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 308,729	\$		\$ 308,729	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			95,166			95,166	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			352,872			352,872	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				232,035		232,035	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RENTALS	39-2					1,862		1,862	12
13	LAB, RADIOLOGY Other (specify): MEDICAL SUPPLIES	39-2 39-2					14,429 23,484		14,429 23,484	13
14	TOTAL			\$		\$ 756,767	\$ 271,810		\$ 1,028,577	14

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 803,216	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 30,000)	2,571,309		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	111,649		6
7	Other Prepaid Expenses	16,267		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,502,441	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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 (spec Goodwill)	7,500,000		22
23	Other(specify): Amort of Goodwill	(166,667)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,333,333	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,835,774	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 252,895	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	750,000		29
30	Accrued Salaries Payable	179,087		30
31	Accrued Taxes Payable (excluding real estate taxes)	70,219		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,252,201	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,919,245		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,919,245	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,171,446	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,664,328	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,835,774	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,478,544)	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4	ADJUSTMENT FOR SALE OF OPERATIONS	1,821,573	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 343,033	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,321,295	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)	\$ 1,321,295	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,664,328	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,114,640	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,114,640	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	387,465	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 387,465	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	4,320	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,250	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,570	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	130,417	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 130,417	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COMPUTER INCOME	62,500	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 62,500	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,700,592	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,797,317	31
32	Health Care	4,046,250	32
33	General Administration	3,008,969	33
	B. Capital Expense		
34	Ownership	1,368,178	34
	C. Ancillary Expense		
35	Special Cost Centers	1,028,577	35
36	Provider Participation Fee	118,036	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,367,327	40
41	Income before Income Taxes (line 30 minus line 40)**	1,333,265	41
42	Income Taxes	(11,970)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,321,295	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 NURSING AND REHAB CENTER**

0050120

Report Period Beginning: **01/01/2008**

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,118	2,198	\$ 81,309	\$ 36.99	1
2	Assistant Director of Nursing	2,976	3,088	104,206	33.75	2
3	Registered Nurses	38,754	40,218	1,215,395	30.22	3
4	Licensed Practical Nurses	5,252	5,450	139,135	25.53	4
5	CNAs & Orderlies	122,222	126,839	1,385,078	10.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,875	12,324	185,475	15.05	8
9	Activity Director	2,993	3,106	48,636	15.66	9
10	Activity Assistants	12,459	12,930	112,232	8.68	10
11	Social Service Workers	7,319	7,596	128,143	16.87	11
12	Dietician					12
13	Food Service Supervisor	2,101	2,180	36,040	16.53	13
14	Head Cook	1,992	2,067	29,787	14.41	14
15	Cook Helpers/Assistants	24,762	25,697	231,014	8.99	15
16	Dishwashers					16
17	Maintenance Workers	5,516	5,724	82,594	14.43	17
18	Housekeepers	44,518	46,200	376,068	8.14	18
19	Laundry	14,482	15,029	120,530	8.02	19
20	Administrator	1,114	1,156	66,731	57.73	20
21	Assistant Administrator	2,038	2,115	77,837	36.80	21
22	Other Administrative	2,219	2,303	20,000	8.68	22
23	Office Manager					23
24	Clerical	18,688	19,394	271,734	14.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,164	2,246	38,512	17.15	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,649	5,862	77,322	13.19	31
32	Other Health Care(specify)	4,610	4,784	141,941	29.67	32
33	Other(specify) <u>SECURITY</u>	2,913	3,023	85,427	28.26	33
34	TOTAL (lines 1 - 33)	338,734	351,529	\$ 5,055,146 *	\$ 14.38	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	\$ 4,620	1-3	35
36	Medical Director	Monthly	45,020	9-3	36
37	Medical Records Consultant	Monthly	10,622	10-3	37
38	Nurse Consultant	Monthly	425	10-3	38
39	Pharmacist Consultant	Monthly	3,545	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	711	11-3	44
45	Social Service Consultant	25	1,610	12-3	45
46	Other(specify)				46
47	<u>Utilization Review Fees</u>	Monthly	1,800	10-3	47
48	<u>Physicians</u>	Monthly	3,955	10-3	48
49	TOTAL (lines 35 - 48)	37	\$ 72,308		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	1,777	61,618	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	1,777	\$ 61,618		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
SAMUEL BIBER	ADMINISTRATOR	0	\$ 36,731	Workers' Compensation Insurance	\$ 154,895	IDPH License Fee	\$ 995	
KAY P ROSS	ADMINISTRATOR	0	30,000	Unemployment Compensation Insurance	56,071	Advertising: Employee Recruitment	40,814	
HELEN SICAT	ASST ADMIN	0	77,837	FICA Taxes	382,713	Health Care Worker Background Check	0	
DANIEL WEISS	OPERATION MGR	0	20,000	Employee Health Insurance	99,053	(Indicate # of checks performed _____)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	13,488	
				EMPLOYEE BENEFITS - OTHER	109,047	MARKETING/ADV/PROMO	15,666	
				EMPLOYEE PHYSICAL EXAMS	440	LICENSES/DUES/SUBSCRIPTIONS	36,479	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(13,488)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(15,666)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 164,568	TOTAL (agree to Schedule V, line 22, col.8)	\$ 802,219	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 78,288	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
WESTMONT G.P. MANAGEMENT FEES			\$ 831,000				Out-of-State Travel	\$
DA WESTMONT MANAGEMENT FEES			225,000					
							In-State Travel	0
							Seminar Expense	2,242
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,056,000	TOTAL			(agree to Sch. V, line 24, col. 8)	\$ 2,242
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			254,686					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 254,686					

* Attach copy of IMRF notifications

**See instructions.

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	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING	7/05	\$ 1,544	3YR	\$ 258	\$ 514	\$ 514	\$ 258												
2	PAINT/DECORATING	7/06	1,882	3YR		314	627	627	314											
3																				
4																				
5																				
6																				
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16																				
17																				
18																				
19																				
20	TOTALS		\$ 3,426		\$ 258	\$ 828	\$ 1,141	\$ 885	\$ 314											

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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 \$932
- (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. \$ 34,248 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 CONVALESCENT CENTER, # 0030015 09/03/08
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 118,036
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? YES
Attach invoices and a summary of services for all architect and appraisal fees