

Facility Name & ID Number Manorcare of Westmont

0049643 Report Period Beginning: 06/01/08 Ending: 05/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	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	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	16,209	10,576	19,714	46,499	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,209	10,576	19,714	46,499	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.19%

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 05/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 155 and days of care provided 15,805

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31 Fiscal Year: 05/31

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

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/08 Ending: 05/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	382,604	27,379	4,203	414,186	3,858	418,044		418,044		1
2	Food Purchase		317,849		317,849		317,849	(2,707)	315,142		2
3	Housekeeping	228,892	34,528	3,270	266,690		266,690		266,690		3
4	Laundry	37,837	17,022	293	55,152		55,152		55,152		4
5	Heat and Other Utilities			277,067	277,067	7,313	284,380		284,380		5
6	Maintenance	50,923	29,929	106,958	187,810		187,810		187,810		6
7	Other (specify):* Med Waste			6,312	6,312		6,312		6,312		7
8	TOTAL General Services	700,256	426,707	398,103	1,525,066	11,171	1,536,237	(2,707)	1,533,530		8
	B. Health Care and Programs										
9	Medical Director			22,500	22,500		22,500		22,500		9
10	Nursing and Medical Records	4,241,840	304,068	39,867	4,585,775	6,186	4,591,961		4,591,961		10
10a	Therapy	1,538,109	18,943	133,264	1,690,316		1,690,316		1,690,316		10a
11	Activities	130,931	9,722	1,005	141,658		141,658		141,658		11
12	Social Services	191,106	165		191,271		191,271		191,271		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,101,986	332,898	196,636	6,631,520	6,186	6,637,706		6,637,706		16
	C. General Administration										
17	Administrative	90,526		539,178	629,704	(102,169)	527,535		527,535		17
18	Directors Fees										18
19	Professional Services			15,537	15,537		15,537	(14,961)	576		19
20	Dues, Fees, Subscriptions & Promotions			97,956	97,956		97,956	(36,966)	60,990		20
21	Clerical & General Office Expenses	401,342	67,885	183,094	652,321		652,321	(53,112)	599,209		21
22	Employee Benefits & Payroll Taxes			1,087,938	1,087,938	64,848	1,152,786		1,152,786		22
23	Inservice Training & Education			13,440	13,440		13,440		13,440		23
24	Travel and Seminar			8,029	8,029		8,029		8,029		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			235,581	235,581		235,581		235,581		26
27	Other (specify):*										27
28	TOTAL General Administration	491,868	67,885	2,180,753	2,740,506	(37,321)	2,703,185	(105,039)	2,598,146		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,294,110	827,490	2,775,492	10,897,092	(19,964)	10,877,128	(107,746)	10,769,382		29

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

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

Facility Name & ID Number

Manorcare of Westmont

#0049643

Report Period Beginning:

06/01/08

Ending:

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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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			643,232	643,232	19,964	663,196		663,196			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,716	4,716		4,716		4,716			32
33	Real Estate Taxes			114,014	114,014		114,014		114,014			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			97,743	97,743		97,743		97,743			35
36	Other (specify):*											36
37	TOTAL Ownership			859,705	859,705	19,964	879,669		879,669			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		672,443		672,443		672,443		672,443			39
40	Barber and Beauty Shops			17,557	17,557		17,557		17,557			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,096	85,096		85,096		85,096			42
43	Other (specify):* IV Therapy, EKG, Xray, & lab		110,313	81,742	192,055		192,055		192,055			43
44	TOTAL Special Cost Centers		782,756	184,395	967,151		967,151		967,151			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,294,110	1,610,246	3,819,592	12,723,948		12,723,948	(107,746)	12,616,202			45

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

Manorcare of Westmont

ID# 0049643

Report Period Beginning: 06/01/08

Ending: 05/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (956)	21	1
2	Miscellaneous Income	4,730	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	3,774		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Westmont# 0049643

Report Period Beginning:

06/01/08

Ending:

05/31/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,707)	0	0	0	0	0	0	0	0	0	0	(2,707)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,707)	0	0	0	0	0	0	0	0	0	0	(2,707)	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	(14,961)	0	0	0	0	0	0	0	0	0	0	(14,961)	19
20	Fees, Subscriptions & Promotions	(36,966)	0	0	0	0	0	0	0	0	0	0	(36,966)	20
21	Clerical & General Office Expenses	(53,112)	0	0	0	0	0	0	0	0	0	0	(53,112)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(105,039)	0	0	0	0	0	0	0	0	0	0	(105,039)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(107,746)	0	0	0	0	0	0	0	0	0	0	(107,746)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Westmont# 0049643

Report Period Beginning:

06/01/08 Ending:05/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(107,746)	0	0	0	0	0	0	0	0	0	0	(107,746)	45

Facility Name & ID Number

Manorcare of Westmont

0049643

Report Period Beginning:

06/01/08

Ending:

05/31/09

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See						
2	V	Page						
3	V	8						
4	V							
5	V	10a						
		Therapy Management	133,264	Heartland Management Services	100.00%	133,264		
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 672,442			\$ 672,442	\$ *	

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

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Manorcare of Westmont

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - -Direct	Accumulated Cost	2,759,273,494	357 Nurs. Fac	\$ 1,686	\$ 0	11,402,280	\$ 7	1
2	1	Dietary - Pooled	Accumulated Cost	3,268,346,175	357 Nurs. Fac	1,103,816	559,529	11,402,280	3,851	2
3	5	Utilities - Direct	Accumulated Cost	2,759,273,494	357 Nurs. Fac	287,502		11,402,280	1,188	3
4	5	Utilities - Pooled	Accumulated Cost	3,268,346,175	357 Nurs. Fac	1,755,769		11,402,280	6,125	4
5	10	Nursing - Direct	Accumulated Cost	2,759,273,494	357 Nurs. Fac	0	0	11,402,280	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,268,346,175	357 Nurs. Fac	1,773,058	1,106,606	11,402,280	6,186	6
7	17	General & Admin - Direct	Accumulated Cost	2,759,276,494	357 Nurs. Fac	30,646,209	36,538,442	11,402,280	126,641	7
8	17	General & Admin - Pooled	Accumulated Cost	3,268,346,175	357 Nurs. Fac	88,964,011	51,489,483	11,402,280	310,368	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,759,273,494	357 Nurs. Fac	6,188,752		11,402,280	25,574	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,268,346,175	357 Nurs. Fac	11,257,416		11,402,280	39,274	10
11	30	Depreciation - Direct	Accumulated Cost	2,759,273,494	357 Nurs. Fac	0		11,402,280	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,268,346,175	357 Nurs. Fac	5,722,441		11,402,280	19,964	12
13										13
14	32	Interest				10,928,075				14
15		Non Nursing Home Allocations				28,224,463				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 186,853,198	\$ 89,694,060		\$ 539,178	25

Facility Name & ID Number

Manorcare of Westmont

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Ending:

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8	Interest Expense / Income									4,716	8							
9	TOTAL Facility Related					\$	\$			\$ 4,716	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$	\$		\$ 4,716	15							

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

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

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

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,189 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility		1977	\$ 195,699	1
2	Facility Addition		2004	33,809	2
3	TOTALS			\$ 229,508	3

Facility Name & ID Number Manorcare of Westmont# 0049643

Report Period Beginning:

06/01/08

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05/31/09**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	155			1977	\$ 1,372,073	\$ 80,681		\$ 80,681	\$	\$ 1,338,100	4
5				2004	1,903,806						5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					399,503		399,503		3,277,648	9
10				1985	42,165						10
11				1986	9,808						11
12				1987	118,541						12
13				1988	118,593						13
14				1989	58,768						14
15				1990	15,910						15
16				1991	58,674						16
17				1992	84,338						17
18				1993	50,656						18
19				1994	697,677						19
20				1995	184,192						20
21				1996	118,190						21
22				1997	90,456						22
23				1998	253,224						23
24				1999	3,181						24
25				2000	85,888						25
26				2001	224,426						26
27		VINYL WALLCOVERING		2002	1,404						27
28		WINDOW TREATMENTS		2002	907						28
29		PAINT, WVC, & CARPET		2002	8,512						29
30		INSTALL PHONE JACKS		2002	476						30
31		ELECTRIC WORK & FIXTURES		2002	2,699						31
32		CONSTRUCTION OF NEW INTERIOR WALL		2002	1,930						32
33		CONCRETE / RETAINING WALL		2002	11,871						33
34		STORAGE ROOM		2003	6,740						34
35		VINYL WALLCOVERING		2003	7,131						35
36		Carpet		2003	1,744						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Westmont# 0049643

Report Period Beginning:

06/01/08

Ending:

05/31/09**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	CONSTRUCTION DEPT. COST & INTEREST	2003	\$ 3,554	\$		\$	\$	\$	37
38	WALLCOVERING & CARPET	2003	16,639						38
39	CABINETS - CUSTOM MADE & INSTALLED	2003	4,875						39
40	WINDOWS INSTALLED & EXTEND WALL	2003	14,827						40
41	BIFOLD OPERATOR DOOR	2003	2,446						41
42	WALLCOVERING & CARPET	2004	2,250						42
43	General Build Overhead & Interest	2004	117,867						43
44	Carpentry	2004	26,990						44
45	Mill Work	2004	4,207						45
46	Doors & Frames	2004	24,238						46
47	Windows	2004	10,470						47
48	Flooring	2004	1,012						48
49	Wallcovering & Corner Guards	2004	99,668						49
50	Fire Sprinkler System	2004	800						50
51	Plumbing	2004	1,626						51
52	Electrical	2004	4,889						52
53	Bldg Addtn - Architect, Engineering, Permits, Plan Reviews	2004	223,090						53
54	Bldg Addtn - General Overhead Costs & Interest	2004	616,107						54
55	Bldg Addtn - Carpeting	2004	21,109						55
56	Bldg Addtn - Wallcovering & Corner Guards	2004	25,299						56
57	Bldg Addtn - Millwork	2004	11,524						57
58	Bldg Addtn - Soil & Concrete Testing, Water & Sewer Fees	2004	108,430						58
59	Bldg Addtn - Land Prep/Improvements for Construction	2004	284,371						59
60	Bldg Addtn - Paving	2004	57,718						60
61	Garage Renov. - Roof, Decking, Door, Siding, Soffits	2004	9,820						61
62	Doors	2004	13,114						62
63	Repair Wall & VWC	2004	7,292						63
64	Door Hardware	2005	5,800						64
65	fire caulking	2005	13,665						65
66	Additional cost for caulking	2005	1,765						66
67	New Door	2005	1,694						67
68	Feed for Door Operator	2005	550						68
69	New Doors	2005	8,861						69
70	TOTAL (lines 4 thru 69)		\$ 7,280,547	\$ 480,184		\$ 480,184	\$	\$ 4,615,748	70

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

Facility Name & ID Number Manorcare of Westmont# 0049643

Report Period Beginning:

06/01/08

Ending:

05/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,280,547	\$ 480,184		\$ 480,184	\$	\$ 4,615,748	1
2	<u>Doors</u>	2005	3,179						2
3	<u>Service Doors</u>	2005	3,179						3
4	<u>Renov - Genreal Overhead & interest</u>	2005	26,091						4
5	<u>Renov - Resilient Flooring</u>	2005	90,087						5
6	<u>Renov - Wallcovering</u>	2005	5,644						6
7	<u>Renov - Carpentry - Supbcontr</u>	2005	10,000						7
8	<u>Renov - Fire Sprinkler System</u>	2005	4,125						8
9	<u>Renov - Wood Doors & Frames</u>	2005	22,840						9
10	<u>Renov - Accoustical Ceiling Tiles</u>	2005	2,500						10
11	<u>New Door & Thresholds</u>	2006	3,200						11
12	<u>Vinyl Covering & Flooring</u>	2005	2,971						12
13	<u>Doors</u>	2006	1,066						13
14	<u>Light poles & base</u>	2005	3,300						14
15	<u>Doors cost adjustment /duplicate</u>	2005	(3,179)						15
16	<u>Renov - general overhead & interest</u>	2006	11,813						16
17	<u>Renov - basic electrical - elevator</u>	2006	60,598						17
18	<u>countertop</u>	2006	1,040						18
19	<u>120V feed</u>	2006	1,118						19
20	<u>ductwork</u>	2006	4,930						20
21	<u>40 beds / assist rails</u>	2006	11,328						21
22	<u>2 resident room doors</u>	2007	1,400						22
23	<u>5 resident room doors</u>	2007	6,300						23
24	<u>5 doors in Resident rooms</u>	2007	2,475						24
25	<u>electrical for steamer</u>	2007	1,629						25
26	<u>13 windows</u>	2007	14,105						26
27	<u>flooring in shower room</u>	2007	6,440						27
28	<u>metal doors</u>	2007	5,379						28
29	<u>Resident Room Doors</u>	2008	7,910						29
30	<u>Parking improvements Prelim site layout</u>	2008	1,250						30
31	<u>Renov - Landscaping Front Entrance</u>	2008	38,406						31
32	<u>Renov - Landscaping General overhead & interest</u>	2008	1,090						32
33	<u>RTU</u>	2008	8,141						33
34	TOTAL (lines 1 thru 33)		\$ 7,640,903	\$ 480,184		\$ 480,184	\$	\$ 4,615,748	34

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

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 12B, Carried Forward		\$ 7,640,903	\$ 480,184		\$ 480,184	\$	\$ 4,615,748	1
2	CO2 System	2008	5,965						2
3	Insulation for RTU	2008	3,445						3
4	Renov - Restrooms- gen overhead & interest	2008	8,867						4
5	Renov - Restrooms - Resilient flooring	2008	10,915						5
6	Renov Restrooms - Wallcovering	2008	7,401						6
7	Renov - Restrooms -HVAC	2008	3,710						7
8	Central Bath Ceramic Tile	2007	4,271						8
9	Renov - Patio & Grill-Gen Overhead & Interest	2008	4,886						9
10	Renov - Patio & Grill addition	2008	35,629						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)		\$ 7,725,992	\$ 480,184		\$ 480,184	\$	\$ 4,615,748	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	\$ 2,385,496	\$ 163,048	\$ 163,048	\$		\$ 1,786,584	71
72	Current Year Purchases	103,085						72
73	Fully Depreciated Assets							73
74	Home Office & Retirements			19,964	19,964			74
75	TOTALS	\$ 2,488,581	\$ 163,048	\$ 183,012	\$ 19,964		\$ 1,786,584	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,444,081	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 643,232	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 663,196	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,964	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,402,332	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: _____

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? _____

16. Rental Amount for movable equipment: \$ 97,743 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	6956 hrs	\$ 289,073	73	\$ 4,354	\$ 6,054	7,029	\$ 299,481	1
2	Licensed Speech and Language Development Therapist	10a	8460 hrs	348,818	795	47,249	12,618	9,255	408,685	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	2717 hrs	111,486	213	12,623	271	2,930	124,380	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				672,443		672,443	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Inhal Ther/X-Ray/Lab</u>	10a	4017	98,468			110,313	4,017	208,781	13
14	TOTAL			\$ 847,845	1,081	\$ 64,226	\$ 801,699	23,231	\$ 1,713,770	14

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

Facility Name & ID Number Manorcare of Westmont# 0049643Report Period Beginning: 06/01/08Ending: 05/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (242,435)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (380,558))	2,295,285		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,741		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,057,591	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	229,508		13
14	Buildings, at Historical Cost	7,725,992		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,488,581		16
17	Accumulated Depreciation (book methods)	(6,402,332)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP</u>	32,645		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,074,394	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,131,985	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 148,724	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	733,546		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	103,794		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Payables</u>	146,819		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,132,883	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	9,996		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,996	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,142,879	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,989,106	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,131,985	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,213,707	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,213,707	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,655,193	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)	\$ 1,655,193	17
	B. Transfers (Itemize):		
18	Change in interdivision	(2,879,794)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,879,794)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,989,106	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Westmont# 0049643Report Period Beginning: 06/01/08Ending: 05/31/09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,521,114	1
2	Discounts and Allowances for all Levels	(2,624,699)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,896,415	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,507,288	6
7	Oxygen	44,713	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,552,001	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	956	12
13	Barber and Beauty Care	19,736	13
14	Non-Patient Meals	2,707	14
15	Telephone, Television and Radio	17	15
16	Rental of Facility Space		16
17	Sale of Drugs	778,162	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,886	19
20	Radiology and X-Ray	32,879	20
21	Other Medical Services	58,580	21
22	Laundry	5,480	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 935,403	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	(4,730)	28
28a	<u>Late Charges</u>	52	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (4,678)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,379,141	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,525,066	31
32	Health Care	6,631,520	32
33	General Administration	2,740,506	33
B. Capital Expense			
34	Ownership	859,705	34
C. Ancillary Expense			
35	Special Cost Centers	882,055	35
36	Provider Participation Fee	85,096	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,723,948	40
41	Income before Income Taxes (line 30 minus line 40)**	1,655,193	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,655,193	43

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

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

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

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

Facility Name & ID Number **Manorcare of Westmont**

0049643

Report Period Beginning:

06/01/08

Ending:

05/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,043	2,215	\$ 101,177	\$ 45.68	1
2	Assistant Director of Nursing	2,791	3,026	108,493	35.85	2
3	Registered Nurses	54,185	58,751	1,988,196	33.84	3
4	Licensed Practical Nurses	21,734	23,565	586,908	24.91	4
5	CNAs & Orderlies	97,977	106,427	1,425,812	13.40	5
6	CNA Trainees					6
7	Licensed Therapist	24,381	26,540	1,024,757	38.61	7
8	Rehab/Therapy Aides	17,773	19,347	513,352	26.53	8
9	Activity Director	8,621	9,359	130,931	13.99	9
10	Activity Assistants					10
11	Social Service Workers	7,808	8,462	191,106	22.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,521	29,903	382,604	12.79	15
16	Dishwashers					16
17	Maintenance Workers	2,072	2,248	50,923	22.65	17
18	Housekeepers	18,350	19,896	228,892	11.50	18
19	Laundry	3,353	3,641	37,837	10.39	19
20	Administrator	2,080	2,080	90,526	43.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,476	22,173	401,342	18.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,855	2,014	31,254	15.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	313,020	339,647	\$ 7,294,110 *	\$ 21.48	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly	22,500	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,003	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	28,503		49

C. CONTRACT NURSES

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

Facility Name & ID Number Manorcare of Westmont# 0049643Report Period Beginning: 06/01/08Ending: 05/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA \$5,886
- (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 \$6155
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5-10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 73,460 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 85,096
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,707
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? NO
Attach invoices and a summary of services for all architect and appraisal fees.