

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,055	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,475	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,137	1,690	10,452	20,279	8
9	SNF/PED					9
10	ICF	41,940	7,658	142	49,740	10
11	ICF/DD	X				11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,077	9,348	10,594	70,019	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.22%

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 125 and days of care provided 8,194

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number

WESTMONT NURSING AND REHAB CEN

0050120

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	299,742	32,266	1,143	333,151		333,151		333,151		1
2	Food Purchase		339,059		339,059		339,059	(1,227)	337,832		2
3	Housekeeping	407,741	82,169		489,910		489,910		489,910		3
4	Laundry	77,610	22,529	5,452	105,591		105,591		105,591		4
5	Heat and Other Utilities			242,559	242,559		242,559	482	243,041		5
6	Maintenance	92,058	55,938	29,192	177,188		177,188	2,546	179,734		6
7	Other (specify):*			12,724	12,724		12,724	24	12,748		7
8	TOTAL General Services	877,151	531,961	291,070	1,700,182		1,700,182	1,825	1,702,007		8
	B. Health Care and Programs										
9	Medical Director			26,030	26,030		26,030		26,030		9
10	Nursing and Medical Records	3,332,395	173,111	43,829	3,549,335		3,549,335		3,549,335		10
10a	Therapy	205,462	4,310		209,772		209,772		209,772		10a
11	Activities	136,527	875	16,638	154,040		154,040		154,040		11
12	Social Services	128,021		1,305	129,326		129,326		129,326		12
13	CNA Training										13
14	Program Transportation			2,119	2,119		2,119		2,119		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,802,405	178,296	89,921	4,070,622		4,070,622		4,070,622		16
	C. General Administration										
17	Administrative	167,259		684,000	851,259		851,259		851,259		17
18	Directors Fees										18
19	Professional Services			64,853	64,853		64,853	69	64,922		19
20	Dues, Fees, Subscriptions & Promotions			66,215	66,215		66,215	(42,605)	23,610		20
21	Clerical & General Office Expenses	331,679	38,626	34,807	405,112		405,112	(121,405)	283,707		21
22	Employee Benefits & Payroll Taxes			778,999	778,999		778,999		778,999		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,677	1,677		1,677		1,677		24
25	Other Admin. Staff Transportation			4,756	4,756		4,756		4,756		25
26	Insurance-Prop.Liab.Malpractice			227,165	227,165		227,165	130	227,295		26
27	Other (specify):*			75,105	75,105		75,105	(75,105)			27
28	TOTAL General Administration	498,938	38,626	1,937,577	2,475,141		2,475,141	(238,916)	2,236,225		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,178,494	748,883	2,318,568	8,245,945		8,245,945	(237,091)	8,008,854		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	0
	REPAIRS & MAINTENANCE	1,143
		0
		1,143
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	5,452
		0
		5,452
5	HEAT & OTHER UTILITIES	
	GAS HEAT	42,562
	ELECTRICITY	96,878
	WATER	103,119
	CABLE TV - LOBBY	0
		0
		242,559
6	MAINTENANCE	
	GROUPS MAINTENANCE	12,857
	PAINTING & DECORATING	
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	633
	ELEVATOR MAINTENANCE & REPAIR	5,725
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,575
	FIRE SERVICE	5,402
		0
		0
		0
		0
		29,192
7	OTHER	
	SCAVENGER	12,724
	SECURITY SERVICE	0
		0
		0
		12,724
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	26,030
		26,030

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	22,850
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	10,358
	PHARMACY CONSULTANT XVIII B 39-2	3,476
	UTILIZATION REVIEW FEES XVIII B ___-2	1,200
	PHYSICIANS XVIII B ___-2	5,645
	PSYCHIATRIC XVIII B ___-2	300
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		43,829
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 CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	16,029
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	609
		0
		16,638
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,305
		0
		1,305
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	2,119
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	684,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	40,388
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	24,465
		0
		64,853
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	36,488
	EMPLOYEE WANT ADS XIX F	9,960
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	10,196
	LICENSES & PERMITS XIX F	3,415
	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	6,156
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		66,215
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	227
	EQUIPMENT REPAIR & MAINTENANCE	2,638
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	10,270
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	295
	TELEPHONE	21,377
	MESSENGER SERVICE	0
		0
		34,807

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	392,311
	UNEMPLOYMENT COMPENSATION XIX D	37,414
	WORKERS COMPENSATION INSURANCE XIX D	120,006
	HOSPITALIZATION INSURANCE XIX D	113,626
	EMPLOYEE BENEFITS - OTHER XIX D	115,642
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		778,999
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,677
	TRAVEL XIX G	0
		1,677
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,756
		4,756
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	227,165
		227,165
27	OTHER	
	BAD DEBTS VI 24	75,105
		75,105

GRAND TOTAL COLUMN 3 OTHER

2,318,568

**WESTMONT NURSING AND REHAB CENTER
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	339,059
LESS SALES TAX	<u>(1,227)</u>
NET FOOD	337,832
TOTAL PATIENT CENSUS	70,019
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	210,057
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	210,057
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	210,057
NET FOOD	337,832
DIVIDE TOTAL MEALS/YEAR	<u>210,057</u>
COST PER MEAL	1.61
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

Facility Name & ID Number

WESTMONT NURSING AND REHAB CENTER

#0050120

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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							390,403	390,403			30
31	Amortization of Pre-Op. & Org.			500,000	500,000		500,000	(500,000)				31
32	Interest			492,651	492,651		492,651	210,676	703,327			32
33	Real Estate Taxes							120,920	120,920			33
34	Rent-Facility & Grounds			942,000	942,000		942,000	(942,000)				34
35	Rent-Equipment & Vehicles			53,804	53,804		53,804	606	54,410			35
36	Other (specify):* OFFICE RENT			14,835	14,835		14,835	(14,835)				36
37	TOTAL Ownership			2,003,290	2,003,290		2,003,290	(734,230)	1,269,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		304,186	778,878	1,083,064		1,083,064		1,083,064			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,713	117,713		117,713		117,713			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		304,186	896,591	1,200,777		1,200,777		1,200,777			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,178,494	1,053,069	5,218,449	11,450,012		11,450,012	(971,321)	10,478,691			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	117,416	30		9
10	Interest and Other Investment Income	(14,998)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,227)	2		13
14	Non-Care Related Interest	(475,480)	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	(10,270)	21		18
19	Entertainment		20		19
20	Contributions	(6,156)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,105)	27		24
25	Fund Raising, Advertising and Promotional	(36,488)	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 SEE PAGE 5A	(610,830)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,113,138)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	141,817		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 141,817		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (971,321)		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

ID# 0050120

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 314	6	1
2	MARKETING SALARY	(111,144)	21	2
3	AMORTIZATION OF GOODWILL	(500,000)	31	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	(610,830)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(1,227)	0	0	0	0	0	0	0	0	0	0	(1,227)	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	482	0	0	0	0	0	0	0	0	482	5
6	Maintenance	314	0	2,232	0	0	0	0	0	0	0	0	2,546	6
7	Other (specify):*	0	0	24	0	0	0	0	0	0	0	0	24	7
8	TOTAL General Services	(913)	0	2,738	0	1,825	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	69	0	0	0	0	0	0	0	0	69	19
20	Fees, Subscriptions & Promotions	(42,644)	0	39	0	0	0	0	0	0	0	0	(42,605)	20
21	Clerical & General Office Expenses	(121,414)	0	9	0	0	0	0	0	0	0	0	(121,405)	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	130	0	0	0	0	0	0	0	0	130	26
27	Other (specify):*	(75,105)	0	0	0	0	0	0	0	0	0	0	(75,105)	27
28	TOTAL General Administration	(239,163)	0	247	0	(238,916)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(240,076)	0	2,985	0	(237,091)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER# 0050120

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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	117,416	271,612	1,375	0	0	0	0	0	0	0	0	390,403	30
31	Amortization of Pre-Op. & Org.	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	31
32	Interest	(490,478)	698,710	2,444	0	0	0	0	0	0	0	0	210,676	32
33	Real Estate Taxes	0	119,024	1,896	0	0	0	0	0	0	0	0	120,920	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	606	0	0	0	0	0	0	0	0	606	35
36	Other (specify):*	0	0	(14,835)	0	0	0	0	0	0	0	0	(14,835)	36
37	TOTAL Ownership	(873,062)	147,346	(8,514)	0	(734,230)	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)	(1,113,138)	147,346	(5,529)	0	(971,321)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				WESTMONT REAL ESTATE, LLC	LINCOLNWOOD	REAL ESTATE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		IME REALTY CORP	LINCOLNWOOD	HOME OFFICE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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)				271,612	271,612	2
3	V	32 INTEREST				645,565	645,565	3
4	V	33 REAL ESTATE TAXES				119,024	119,024	4
5	V	32 MIP INSURANCE				53,145	53,145	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			\$ 1,089,346	\$ * 147,346	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				482	482
17	V	6 PAINTERS FEES				974	974
18	V	6 REPAIRS/MAINT				1,258	1,258
19	V	7 ALARM SERVICE				24	24
20	V	19 ACCOUNTING FEES				69	69
21	V	21 OFFICE EXPENSE				9	9
22	V	26 INSURANCE				130	130
23	V	30 DEPRECIATION (SL)				1,375	1,375
24	V	32 INTEREST				2,444	2,444
25	V	33 RE TAX				1,896	1,896
26	V	35 STORAGE FEES				606	606
27	V	20 LICENSES & PERMITS				39	39
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			\$ 9,306	\$ * (5,529)

* 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:

01/01/2009

Ending:

12/31/2009

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	DANIEL WEISS	GEN. PARTNERS	ADMINISTRAT.	40.00	SEE			MGMT FEE	\$ 342,000	17-3	1
2	AVRUM WEINFELD	GEN. PARTNERS	ADMINISTRAT.	40.00	ATTACHED SCHEDULES			MGMT FEE	342,000	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 684,000		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:

01/01/2009

Ending: 2/31/2009

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 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

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	\$ 6,106	\$ 14,835	\$ 482	1
2	6	PAINTERS FEES	INCOME	187,059	14	12,303	14,835	974	2
3	6	REPAIRS/MAINT	INCOME	187,059	14	15,863	14,835	1,258	3
4	7	ALARM SERVICE	INCOME	187,059	14	301	14,835	24	4
5	19	ACCOUNTING FEES	INCOME	187,059	14	897	14,835	69	5
6	21	OFFICE EXPENSE	INCOME	187,059	14	136	14,835	9	6
7	26	INSURANCE	INCOME	187,059	14	1,627	14,835	130	7
8	30	DEPRECIATION (SL)	INCOME	187,059	14	17,336	14,835	1,375	8
9	32	INTEREST	INCOME	187,059	14	30,806	14,835	2,444	9
10	33	RE TAX	INCOME	187,059	14	23,914	14,835	1,896	10
11	35	STORAGE FEES	INCOME	187,059	14	7,635	14,835	606	11
12	20	LICENSES & PERMITS	INCOME	187,059	14	468	14,835	39	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					\$ 117,392	\$	\$ 9,306	25

Facility Name & ID Number WESTMONT NURSING AND REHAB CEN

0050120

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	RELATED PARTY: WESTMONT REAL ESTATE, LLC				\$	\$			\$	1										
2	CAMBRIDGE REALTY	X	MORTGAGE	\$77,424.46	11/17/06	10,881,400	10,579,668	12/01/41	5.9800	635,619	2									
3	LOAN COSTS	X	LOAN COSTS	W/O OVER LOAN		348,110	316,973			9,946	3									
4	MIP INSURANCE									53,145	4									
5											5									
Working Capital																				
6	MB FINANCIAL	X	WORKING CAPITAL	DEMAND					PRIME+	17,171	6									
7											7									
8	IME REALTY ALLOCATION									2,444	8									
9	TOTAL Facility Related			\$77,424.46		\$ 11,229,510	\$ 10,896,641			\$ 718,325	9									
B. Non-Facility Related*																				
10	BRICKYRD BANK	X	GOODWILL	\$29,590.38	09/08	1,500,000	1,148,527	09/13	6.7500	88,446	10									
11	GOODWILL	X	GOODWILL	\$42,088.99	09/08	7,500,000	6,386,045	09/33	6.0000	387,034	11									
12											12									
13											13									
14	TOTAL Non-Facility Related			\$71,679.37		\$ 9,000,000	\$ 7,534,572			\$ 475,480	14									
15	TOTALS (line 9+line14)					\$ 20,229,510	\$ 18,431,213			\$ 1,193,805	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 53,145 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

1. Real Estate Tax accrual used on 2008 report.		\$	104,546	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.)		\$	111,229	2
3. Under or (over) accrual (line 2 minus line 1).		\$	6,683	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	112,341	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.		\$	119,024	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	89,708	8
	2005	91,769	9
	2006	101,943	10
	2007	103,511	11
	2008	111,229	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL
THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-22-101-001</u>	<u>NURSING HOME</u>	\$ <u>99,348.32</u>	\$ <u>99,348.32</u>
2. <u>09-22-101-002</u>	<u>NURSING HOME</u>	\$ <u>4,927.14</u>	\$ <u>4,927.14</u>
3. <u>09-22-101-003</u>	<u>NURSING HOME</u>	\$ <u>6,953.22</u>	\$ <u>6,953.22</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>111,228.68</u>	\$ <u>111,228.68</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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	2	3	4	
	Use	Square Feet	Year Acquired	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:

01/01/2009 Ending: 12/31/2009

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	\$	\$ 1,889,774	4
5											5
6											6
7											7
8		IME 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		20	(789)	(789)	31,143	10
11		IMPROVEMENTS		1988	44,614		31.5	1,416	1,416	30,439	11
12		IMPROVEMENTS		1989	40,935		31.5	1,299	1,299	26,571	12
13		DRIVEWAY		1989	17,137		15	(247)	(247)	17,137	13
14		IMPROVEMENTS		1990	37,367		31.5	1,186	1,186	23,076	14
15		IMPROVEMENTS		1991	45,002		31.5	1,428	1,428	26,179	15
16		IMPROVEMENTS		1992	49,649		31.5	1,577	1,577	27,504	16
17		ROOF TOP A/C UNITS		1993	9,100		31.5	289	289	4,889	17
18		IMPROVEMENTS		1993	53,243		39	1,366	1,366	22,389	18
19		IMPROVEMENTS		1994	31,230		39	801	801	12,532	19
20		FLOOR COVERING		1995	795		15	53	53	795	20
21		HAND RAIL		1995	2,249		39	58	58	863	21
22		FLOOR TILES		1995	5,471		39	140	140	2,048	22
23		WINDOW A/C UNITS		1995	14,146		39	363	363	5,247	23
24		ARJO TUB & ATTACHED PLUMBING		1995	12,056		39	309	309	4,494	24
25		ALARM		1995	1,337		39	34	34	492	25
26		LAUNDRY BUILDING		1995	35,000		39	897	897	12,820	26
27		ROOF		1995	5,520		39	142	142	2,029	27
28		WINDOWS		1995	9,478		39	243	243	3,453	28
29		DOOR EDGE & DOOR FRAME		1996	2,099		39	54	54	754	29
30		LAUNDRY BUILDING		1996	175,187		39	4,491	4,491	60,826	30
31		AIR COOLERS		1996	6,642		39	171	171	2,306	31
32		RACING CAGE		1996	3,987		39	102	102	1,381	32
33		HAND RAIL		1996	1,156		39	30	30	401	33
34		WINDOWS		1996	11,496		39	295	295	3,946	34
35		TACK ROOM		1996	2,139		39	55	55	731	35
36		NEW CONFERENCE ROOM TILE		1997	2,938		39	76		934	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER

0050120

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	1997	\$ 1,478	\$	39	\$ 38	\$ 38	\$ 467	37
38	1997	5,397		39	138	138	1,674	38
39	1997	1,382		39	35	35	424	39
40	1997	1,107		39	28	28	363	40
41	1998	4,927		39	126	126	1,476	41
42	1998	42,711		15	2,990	2,990	32,698	42
43	1998	6,223		39	160	160	1,903	43
44	1998	12,715		39	326	326	3,627	44
45	1999	10,473		39	269	269	2,948	45
46	1999	3,452		39	89	89	953	46
47	1999	1,495		39	38	38	407	47
48	1999	2,877		39	74	74	786	48
49	1999	8,988		39	230	230	2,425	49
50	1999	2,370		39	61	61	638	50
51	1999	2,760		39	71	71	725	51
52	1999	2,931		39	75	75	759	52
53	1999	3,073		39	79	79	800	53
54	1999	1,212		39	31	31	314	54
55	1999	7,200		39	185	185	1,873	55
56	1999	2,738		39	70	70	703	56
57	2000	3,265		20	163	163	1,630	57
58	2000	3,573		27.5	130	130	1,208	58
59	2000	27,448		27.5	998	998	9,190	59
60	2000	4,200		27.5	153	153	1,409	60
61	2000	2,910		27.5	106	106	958	61
62	2000	4,694		27.5	171	171	1,546	62
63	2000	80,523		20	4,026	4,026	40,260	63
64	2001	30,586		27.5	1,112	1,112	9,777	64
65	2001	107,341		27.5	3,903	3,903	32,688	65
66	2001	9,108		27.5	331	331	2,662	66
67	2001	12,464		27.5	453	453	3,643	67
68	2001	270,861		20	13,543	13,543	121,887	68
69	2002	29,114		20	1,456	1,456	11,648	69
70		\$ 6,386,654	\$ 129,074		\$ 176,571	\$ 47,421	\$ 2,551,263	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:

01/01/2009 Ending: 12/31/2009

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	10
	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	\$ 129,074		\$ 176,571	\$ 47,497	\$ 2,551,263	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997		15	600	600	4,380	2
3	SHOWER ROOM	2002	30,924		27.5	1,125	1,125	8,109	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010		27.5	328	328	2,310	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891		27.5	541	541	3,810	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056		20	2,003	2,003	16,024	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499		20	575	575	4,600	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767		27.5	464	464	2,997	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152		27.5	1,133	1,133	7,317	9
10	THERAPY ROOM -FLOORING	2003	87,509		27.5	3,182	3,182	20,550	10
11	CONFERENCE ROOM-FLOORING	2003	2,073		27.5	76	76	491	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421		27.5	270	270	1,474	12
13	PHONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825		27.5	3,266	3,266	17,283	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925		27.5	1,852	1,852	9,646	14
15	RESIDENT ROOMS-FLOORING	2005	9,821		27.5	357	357	1,681	15
16	INSTALL CABLING SYSTEM	2005	46,771		27.5	1,701	1,701	7,867	16
17	INSTALL TWO AUTOMATIC SLIDING DOOR	2005	28,000		27.5	1,018	1,018	4,114	17
18	1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE	2005	58,286		20	2,914	2,914	14,570	18
19	INSTALL DOORS - F WING, RESIDENT ROOMS	2006	4,260		27.5	155	155	601	19
20	WALLCOVERING, FLOORING - 1ST FLOOR CORRID	2006	63,838		27.5	2,321	2,321	8,800	20
21	AIR CONDITIONS	2006	7,968		27.5	289	289	1,007	21
22	REPLACEMENT WALK - IN FREEZER DOOR	2006	4,652		27.5	169	169	599	22
23	REPLACEMENT OF KITCHEN TILES	2007	13,200		27.5	380	380	1,140	23
24									24
25	WESTMONT REAL ESTATE, LLC								25
26	NEW PARKING LOT	2007	206,876	13,792	15	13,792		31,082	26
27	RESIDENT ROOMS-FLOORING, WINGS B,C,D,E,F	2007	235,801	8,575	27.5	8,575		21,080	27
28	RESIDENT ROOMS-PAINTING, WINGS B,C,D,E,F	2007	84,360	16,197	5	16,197		60,065	28
29	INSTALL NEW FIRE DOORS IN EXIST. FRAME E WING	2007	3,108	113	27.5	113		278	29
30	TUCKPOINTING, AIR CONDITIONS, WATER HEATER	2007	18,594	3,570	5	3,570		13,239	30
31	INSTALLATION OF RAILLING ON EXTERIOR STAIRS	2007	6,407	233	27.5	233		572	31
32	REPLACE EXISTING RECEIVING DR/FRAME/HARDWARE	2007	3,108	113	27.5	113		278	32
33	AIR CONDITIONS	2008	12,661	2,026	5	2,026		9,623	33
34	TOTAL (lines 1 thru 33)		\$ 7,591,414	\$ 173,693		\$ 245,909	\$ 72,216	\$ 2,826,850	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	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	\$ 173,693		\$ 245,909	\$ 72,216	\$ 2,826,850	1
2	2008	3,640	132	27.5	132		192	2
3	2008	2,869	105	27.5	105		153	3
4	2008	2,948	107	27.5	107		157	4
5	2009	103,122	20,624	5	20,624		20,624	5
6	2009	9,397	5,639	5	5,639		5,639	6
7	2009	16,265	3,253	5	3,253		3,253	7
8	2009	8,020	134	15	134		134	8
9	2009	2,371	68	27.5	68		68	9
10	2009	3,825	110	27.5	110		110	10
11	2009	5,362	155	27.5	155		155	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		\$ 7,749,233	\$ 204,020		\$ 276,236	\$ 72,216	\$ 2,857,335	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	\$ 452,498	\$	\$ 45,200	\$ 45,200	3-10	\$ 308,022	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	644,507					644,507	73
74	RELATED PARTY SL DEPRECIATION		68,967	68,967				74
75	TOTALS	\$ 1,097,005	\$ 68,967	\$ 114,167	\$ 45,200		\$ 952,529	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	2	
	Reference	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)	\$ 9,606,064	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 272,987	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 390,403	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 117,416	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,809,864	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: \$ 44,469 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	<u>FACILITY</u>	<u>2007 FORD WAGON</u>	\$ <u>775.00</u>	\$ <u>9,335</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>775.00</u>	\$ <u>9,335</u>	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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	39-3	hrs	\$		\$ 279,886	\$		\$ 279,886	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			134,319			134,319	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			364,673			364,673	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				257,834		257,834	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	RADIOLOGY, LABORATORY Other (specify): MEDICAL SUPPLIES	39-2 39-2					16,462 29,890		16,462 29,890	13
14	TOTAL			\$		\$ 778,878	\$ 304,186		\$ 1,083,064	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: 01/01/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 271,716	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,454,980		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	131,002		6
7	Other Prepaid Expenses	14,904		7
8	Accounts Receivable (owners or related parties)	76,826		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,949,428	\$	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 (spe GOODWILL)	7,500,000		22
23	Other(specify): AMORT OF GOODWILL	(666,667)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,833,333	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,782,761	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 254,662	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	118		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	184,443		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,150		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)	\$ 460,373	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,534,572		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)	\$ 7,534,572	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,994,945	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 787,816	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,782,761	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,664,328	1
2	Restatements (describe):		2
3	ADJUSTMENT FOR SALE OF OPERATIONS	(2,360,149)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (695,821)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	933,637	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	550,000	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)	\$ 1,483,637	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)	\$ 787,816	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	\$ 11,939,758	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,939,758	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	365,243	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 365,243	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		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)	\$ 1,250	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14,998	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,998	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>COMPUTER INCOME</u>	62,400	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 62,400	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,383,649	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,700,182	31
32	Health Care	4,070,622	32
33	General Administration	2,475,141	33
B. Capital Expense			
34	Ownership	2,003,290	34
C. Ancillary Expense			
35	Special Cost Centers	1,083,064	35
36	Provider Participation Fee	117,713	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,450,012	40
41	Income before Income Taxes (line 30 minus line 40)**	933,637	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 933,637	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:

01/01/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,852	2,012	\$ 76,043	\$ 37.79	1
2	Assistant Director of Nursing	2,115	2,155	65,974	30.61	2
3	Registered Nurses	31,324	33,095	1,075,490	32.50	3
4	Licensed Practical Nurses	26,609	27,278	569,081	20.86	4
5	CNAs & Orderlies	120,134	123,713	1,295,928	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,022	13,961	205,462	14.72	8
9	Activity Director	2,294	2,374	30,326	12.77	9
10	Activity Assistants	12,109	12,478	106,201	8.51	10
11	Social Service Workers	6,784	7,248	128,021	17.66	11
12	Dietician					12
13	Food Service Supervisor	1,908	2,100	36,193	17.23	13
14	Head Cook	1,615	1,795	24,469	13.63	14
15	Cook Helpers/Assistants	25,555	27,013	239,080	8.85	15
16	Dishwashers					16
17	Maintenance Workers	6,075	6,427	92,058	14.32	17
18	Housekeepers	46,619	48,484	407,741	8.41	18
19	Laundry	9,355	9,823	77,610	7.90	19
20	Administrator	2,068	2,100	89,156	42.46	20
21	Assistant Administrator	1,868	2,140	78,103	36.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,758	21,588	331,679	15.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,956	2,108	36,908	17.51	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,762	6,250	81,628	13.06	31
32	Other Health C: <u>MDS</u>	3,970	4,545	131,343	28.90	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	343,752	358,687	\$ 5,178,494 *	\$ 14.44	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	\$ 0	1-3	35	
36	Medical Director	26,030	9-3	36	
37	Medical Records Consultant	10,358	10-3	37	
38	Nurse Consultant	0	10-3	38	
39	Pharmacist Consultant	3,476	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	11	11-3	44	
45	Social Service Consultant	23	12-3	45	
46	Other(specify) <u>Psychiatric</u>	Monthly	300	10-3	46
47	<u>Utilization Review Fees</u>	Monthly	1,200	10-3	47
48	<u>Physicians</u>	Monthly	5,645	10-3	48
49	TOTAL (lines 35 - 48)	34	\$ 48,923		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	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	7/06	\$ 1,882	3 YRS	\$ 314	\$ 627	\$ 627	\$ 314	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 1,882		\$ 314	\$ 627	\$ 627	\$ 314	\$	\$	\$	\$

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 \$8,857
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,010 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. \$ 117,713
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.