

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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

<p>I. IDPH License ID Number: <u>0050120</u></p> <p>Facility Name: <u>WESTMONT NURSING & REHAB CTR</u></p> <p>Address: <u>6501 S CASS AVE</u> <u>WESTMONT</u> <u>60559</u> Number City Zip Code</p> <p>County: <u>DUPAGE</u></p> <p>Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>09/03/08</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>SANFORD BOKOR</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2013</u> to <u>12/31/2013</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>AVRUM WEINFELD</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>CEO</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KBKB, LTD.</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td></td> <td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>AVRUM WEINFELD</u> (Date) _____		(Title) <u>CEO</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u>	(Firm Name & Address) <u>KBKB, LTD.</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number WESTMONT NURSING & REHAB CTR

0050120 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	8,067	2,329	9,662	20,058	8
9	SNF/PED					9
10	ICF	43,075	6,359	86	49,520	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,142	8,688	9,748	69,578	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.66%

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 9,005

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number WESTMONT NURSING & REHAB CTR # 0050120 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	344,170	45,575	26,306	416,051		416,051	(11,142)	404,909		1
2	Food Purchase		388,059		388,059		388,059	(1,237)	386,822		2
3	Housekeeping	375,333	71,788		447,121		447,121		447,121		3
4	Laundry	46,958	1,522	252,734	301,214		301,214		301,214		4
5	Heat and Other Utilities			256,126	256,126		256,126	569	256,695		5
6	Maintenance	92,498	49,952	38,805	181,255		181,255	1,213	182,468		6
7	Other (specify):*			13,441	13,441		13,441		13,441		7
8	TOTAL General Services	858,959	556,896	587,412	2,003,267		2,003,267	(10,597)	1,992,670		8
	B. Health Care and Programs										
9	Medical Director			54,810	54,810		54,810		54,810		9
10	Nursing and Medical Records	3,853,498	285,995	170,581	4,310,074		4,310,074	(83,075)	4,226,999		10
10a	Therapy	203,320	23,116		226,436		226,436		226,436		10a
11	Activities	176,356	2,728	1,190	180,274		180,274		180,274		11
12	Social Services	140,632		1,449	142,081		142,081		142,081		12
13	CNA Training										13
14	Program Transportation			812	812		812		812		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,373,806	311,839	228,842	4,914,487		4,914,487	(83,075)	4,831,412		16
	C. General Administration										
17	Administrative	159,139		810,000	969,139		969,139	(609,567)	359,572		17
18	Directors Fees										18
19	Professional Services			164,076	164,076		164,076	12,501	176,577		19
20	Dues, Fees, Subscriptions & Promotions			100,388	100,388		100,388	(68,976)	31,412		20
21	Clerical & General Office Expenses	314,915	62,909	77,886	455,710		455,710	(45,429)	410,281		21
22	Employee Benefits & Payroll Taxes			958,517	958,517		958,517	(8,881)	949,636		22
23	Inservice Training & Education			1,866	1,866		1,866	747	2,613		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			21,132	21,132		21,132	593	21,725		25
26	Insurance-Prop.Liab.Malpractice			257,736	257,736		257,736	1,527	259,263		26
27	Other (specify):*			111,834	111,834		111,834	(98,114)	13,720		27
28	TOTAL General Administration	474,054	62,909	2,503,435	3,040,398		3,040,398	(815,599)	2,224,799		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,706,819	931,644	3,319,689	9,958,152		9,958,152	(909,271)	9,048,881		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	22,735
	REPAIRS & MAINTENANCE	3,571
		0
		26,306
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	9,645
	CONTRACTED LAUNDRY SERVICES	243,089
		252,734
5	HEAT & OTHER UTILITIES	
	GAS HEAT	26,072
	ELECTRICITY	90,194
	WATER	135,880
	CABLE TV - LOBBY	3,980
		0
		256,126
6	MAINTENANCE	
	GROUNDS MAINTENANCE	13,915
	PAINTING & DECORATING	1,688
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	442
	ELEVATOR MAINTENANCE & REPAIR	7,080
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,900
	FIRE SERVICE	11,780
		0
		0
		0
		0
		38,805
7	OTHER	
	SCAVENGER	10,028
	SECURITY SERVICE	3,413
		0
		0
		13,441
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	54,810
		54,810

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	26,363
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	660
	PHARMACY CONSULTANT XVIII B 39-2	3,447
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	413
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	139,698
		0
		0
		170,581
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	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	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,190
		0
		1,190
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	1,449
	SOCIAL WORKER XVIII B 45-2	0
		1,449
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	812
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	810,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	53,748
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	110,328
		0
		164,076
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	67,940
	EMPLOYEE WANT ADS XIX F	771
	CONTRIBUTIONS VI 20 XIX F	300
	DUES & SUBSCRIPTIONS XIX F	14,959
	LICENSES & PERMITS XIX F	7,423
	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	7,515
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,280
	PATIENT BACKGROUND CHECKS XIX F	200
		100,388
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	52
	EQUIPMENT REPAIR & MAINTENANCE	35,958
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	3,316
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	38,560
	MESSENGER SERVICE	0
		0
		77,886

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	428,817
	UNEMPLOYMENT COMPENSATION XIX D	117,625
	WORKERS COMPENSATION INSURANC XIX D	161,792
	HOSPITALIZATION INSURANCE XIX D	124,013
	EMPLOYEE BENEFITS - OTHER XIX D	117,389
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	8,881
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		958,517
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,866
		1,866
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	21,132
		21,132
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	257,736
		257,736
27	OTHER	
	BAD DEBTS VI 24	111,834
		111,834

GRAND TOTAL COLUMN 3 OTHER

3,319,689

WESTMONT NURSING & REHAB CTR
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	388,059
LESS SALES TAX	<u>(1,237)</u>
NET FOOD	386,822
TOTAL PATIENT CENSUS	69,578
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	208,734
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	208,734
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	208,734
NET FOOD	386,822
DIVIDE TOTAL MEALS/YEAR	<u>208,734</u>
COST PER MEAL	1.85
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

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			42,598	42,598	42,598	253,313	295,911				30
31	Amortization of Pre-Op. & Org.			500,000	500,000	500,000	(500,000)					31
32	Interest			392,126	392,126	392,126	(84,590)	307,536				32
33	Real Estate Taxes						104,395	104,395				33
34	Rent-Facility & Grounds			832,512	832,512	832,512	(823,732)	8,780				34
35	Rent-Equipment & Vehicles			69,759	69,759	69,759	3,205	72,964				35
36	Other (specify):* OFFICE RENT			15,573	15,573	15,573	37,260	52,833				36
37	TOTAL Ownership			1,852,568	1,852,568	1,852,568	(1,010,149)	842,419				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		270,251	1,425,430	1,695,681	1,695,681		1,695,681				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			487,742	487,742	487,742		487,742				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		270,251	1,913,172	2,183,423	2,183,423		2,183,423				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,706,819	1,201,895	7,085,429	13,994,143	13,994,143	(1,919,420)	12,074,723				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	58,153	30		9
10	Interest and Other Investment Income	(131,786)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,237)	2		13
14	Non-Care Related Interest	(355,107)	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	(3,316)	21		18
19	Entertainment		20		19
20	Contributions	(7,815)	20		20
21	Owner or Key-Man Insurance	(8,881)	22		21
22	Special Legal Fees & Legal Retainers	(9,251)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(111,834)	27		24
25	Fund Raising, Advertising and Promotional	(67,940)	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	(563,266)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,202,280)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(717,140)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (717,140)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,919,420)		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

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
WESTMONT NURSING & REHAB CTR

ID# 0050120
Report Period Beginning: 01/01/2013
Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (58,466)	21	1
2	AMORTIZATION OF GOODWILL	(500,000)	31	2
3	MAKETING STAFF TRANSPORTATION	(4,800)	25	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(563,266)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTMONT NURSING & REHAB CTR

0050120

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	(11,142)	0	0	0	0	0	0	0	(11,142)	1
2	Food Purchase	(1,237)	0	0	0	0	0	0	0	0	0	0	(1,237)	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	450	119	0	0	0	0	0	0	0	569	5
6	Maintenance	0	0	961	252	0	0	0	0	0	0	0	1,213	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,237)	0	1,411	(10,771)	0	(10,597)	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	(83,075)	0	0	0	0	0	0	0	(83,075)	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	(83,075)	0	(83,075)	16						
	C. General Administration													
17	Administrative	0	0	(609,567)	0	0	0	0	0	0	0	0	(609,567)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,251)	8,500	987	12,265	0	0	0	0	0	0	0	12,501	19
20	Fees, Subscriptions & Promotions	(75,755)	0	44	6,735	0	0	0	0	0	0	0	(68,976)	20
21	Clerical & General Office Expenses	(61,782)	0	0	16,353	0	0	0	0	0	0	0	(45,429)	21
22	Employee Benefits & Payroll Taxes	(8,881)	0	0	0	0	0	0	0	0	0	0	(8,881)	22
23	Inservice Training & Education	0	0	0	747	0	0	0	0	0	0	0	747	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(4,800)	0	0	5,393	0	0	0	0	0	0	0	593	25
26	Insurance-Prop.Liab.Malpractice	0	0	103	1,424	0	0	0	0	0	0	0	1,527	26
27	Other (specify):*	(111,834)	0	0	13,720	0	0	0	0	0	0	0	(98,114)	27
28	TOTAL General Administration	(272,303)	8,500	(608,433)	56,637	0	(815,599)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(273,540)	8,500	(607,022)	(37,209)	0	(909,271)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTMONT NURSING & REHAB CTR

0050120

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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	58,153	192,808	1,503	849	0	0	0	0	0	0	0	253,313	30
31	Amortization of Pre-Op. & Org.	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	31
32	Interest	(486,893)	401,302	792	209	0	0	0	0	0	0	0	(84,590)	32
33	Real Estate Taxes	0	100,796	2,852	747	0	0	0	0	0	0	0	104,395	33
34	Rent-Facility & Grounds	0	(832,512)	0	8,780	0	0	0	0	0	0	0	(823,732)	34
35	Rent-Equipment & Vehicles	0	0	803	2,402	0	0	0	0	0	0	0	3,205	35
36	Other (specify):*	0	52,833	(15,573)	0	0	0	0	0	0	0	0	37,260	36
37	TOTAL Ownership	(928,740)	(84,773)	(9,623)	12,987	0	(1,010,149)	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)	(1,202,280)	(76,273)	(616,645)	(24,222)	0	0	0	0	0	0	0	(1,919,420)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 832,512	WESTMONT REAL ESTATE, LLC		\$	(832,512)	1
2	V	30 DEPRECIATION (SL)				192,808	192,808	2
3	V	32 INTEREST				397,554	397,554	3
4	V	32 AMORT LOAN COST				3,748	3,748	4
5	V	33 REAL ESTATE TAXES				100,796	100,796	5
6	V	36 MIP INSURANCE				52,833	52,833	6
7	V	19 ACCOUNTING FEES				8,500	8,500	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 832,512			\$ 756,239	\$ * (76,273)	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	\$ 15,573	IME REALTY CORP		\$	\$ (15,573)
16	V	5 UTILITIES				450	450
17	V	6 REPAIRS/MAINT				961	961
18	V	19 ACCOUNTING FEES				87	87
19	V	20 LICENSES & PERMITS				44	44
20	V	26 INSURANCE				103	103
21	V	30 DEPRECIATION (SL)				1,503	1,503
22	V	32 INTEREST				792	792
23	V	33 RE TAX				2,852	2,852
24	V	35 STORAGE FEES				803	803
25	V						
26	V						
27	V						
28	V						
29	V						
30	V	17 MANAGEMENT FEES	810,000	DA WESTMONT			(810,000)
31	V	19 ACCOUNTING FEES				900	900
32	V	17 ADMIN CONSULTANT-S.HOLT				122,163	122,163
33	V	17 ADMIN CONSULTANT-A.R.M.				78,270	78,270
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 825,573			\$ 208,928	\$ * (616,645)

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

Facility Name & ID Number WESTMONT NURSING & REHAB CTR# 0050120Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	1 DIETICIAN CONSULTANT	\$ 22,500	BRIA HEALTH SERVICES, LLC		\$	\$ (22,500)
16	V	10 NURSING CONSULTING	125,300				(125,300)
17	V	19 PURCHASING CONSULTING.	45,000				(45,000)
18	V	1 DIETARY SALARIES				11,358	11,358
19	V	5 UTILITIES				119	119
20	V	6 REPAIR/MAINT				252	252
21	V	10 NURSING SALARIES				42,225	42,225
22	V	19 PROFESSIONAL FEES				57,265	57,265
23	V	20 WANT ADS, LICENSES				6,735	6,735
24	V	21 TOTAL OFFICE				16,353	16,353
25	V	23 SEMINARS				747	747
26	V	25 TRANSPORTATION				5,393	5,393
27	V	26 INSURANCE				1,424	1,424
28	V	27 EMPLOYEE BENEFITS				13,720	13,720
29	V	30 DEPRECIATION (SL)				849	849
30	V	32 INTEREST				209	209
31	V	33 RE TAX				747	747
32	V	34 OFFICE RENT				8,780	8,780
33	V	35 EQUIPMENT RENT				2,402	2,402
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 192,800			\$ 168,578	\$ * (24,222)

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

Facility Name & ID Number

WESTMONT NURSING & REHAB CTR

0050120

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	AVRUM & DEVORAH WEINFELD	40.00	ATRIUM HEALTHCARE & REHAB	COHOKIA	WESTMONT REAL			2
3					ESTATE, LLC	LINCOLNWOOD	REAL ESTATE	3
4	DANIEL & REBECCA WEISS	40.00	FOREST EDGE HEALTHCARE REHAB	CHICAGO				4
5					IME REALTY CORP	LINCOLNWOOD	HOME OFFICE	5
6	MIRIAM ROBINSON	20.00	BELLEVILLE HEALTHCARE & REHAB	BELLEVILLE				6
7					DA WESTMONT	LINCOLNWOOD	MGMT CONSULT	7
8			GENEVA NURSING & REHAB	GENEVA				8
9					BRIA HEALTH			9
10			LAKE PARK	WAUKEGAN	SERVICES, LLC	LINCOLNWOOD	MGMT SERVICES	10
11								11
12			MST HEALTH CARE PROPERTIES	SOUTH CHICAGO				12
13				HEIGHTS				13
14								14
15			PALOS HILLS HEALTHCARE	PALOS HILLS				15
16								16
17			RIVER OAKS HEALTHCARE REHAB	BURNHAM				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

Facility Name & ID Number WESTMONT NURSING & REHAB CTR # 0050120 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	ALLOCATION FROM DA WESTMONT:				SEE ATTACHED				\$	1	
2	FLORA WEISS (A.R.M. ENTERPRISES)	ADMIN CONSULTANT		0.00	SCHEDULE	10	14.29	CONSULT FEE	78,270	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 78,270		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 & REHAB CTR

0050120

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	121,840	6	\$ 3,521	\$ 15,573	\$ 450	1
2	6	REPAIRS/MAINT	INCOME	121,840	6	7,519	15,573	961	2
3	19	ACCOUNTING FEES	INCOME	121,840	6	678	15,573	87	3
4	20	LICENSES & PERMITS	INCOME	121,840	6	345	15,573	44	4
5	26	INSURANCE	INCOME	121,840	6	807	15,573	103	5
6	30	DEPRECIATION (SL)	INCOME	121,840	6	11,757	15,573	1,503	6
7	32	INTEREST	INCOME	121,840	6	6,197	15,573	792	7
8	33	RE TAX	INCOME	121,840	6	22,310	15,573	2,852	8
9	35	STORAGE FEES	INCOME	121,840	6	6,286	15,573	803	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	TOTALS					\$ 59,420	\$	\$ 7,595	25

Facility Name & ID Number WESTMONT NURSING & REHAB CTR

0050120 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization DA WESTMONT
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	ACCOUNTING FEES	CENSUS DAYS	177,788	3	\$ 2,300	\$ 69,578	\$ 900	1
2	17	ADMIN CONSULTANT-S.HOLT	CENSUS DAYS	69,578	1	122,163	69,578	122,163	2
3	17	ADMIN CONSULTANT-A.R.M.	CENSUS DAYS	177,788	3	200,000	69,578	78,270	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	TOTALS				\$ 324,463	\$		\$ 201,333	25

Facility Name & ID Number WESTMONT NURSING & REHAB CTR

0050120

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization BRIA HEALTH SERVICES, LLC
 Street Address 6865 N LINCOLN AVE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT CENSUS	475,523	8	\$ 77,622	\$ 69,578	\$ 11,358	1
2	5	UTILITIES	PATIENT CENSUS	475,523	8	806	69,578	118	2
3	6	REPAIR/MAINT	PATIENT CENSUS	475,523	8	1,722	69,578	252	3
4	10	NURSING SALARIES	PATIENT CENSUS	475,523	8	288,582	288,582	42,225	4
5	19	PROFESSIONAL FEES	PATIENT CENSUS	475,523	8	391,370	100,000	57,265	5
6	20	WANT ADS, LICENSES	PATIENT CENSUS	475,523	8	46,030	69,578	6,735	6
7	21	TOTAL OFFICE	PATIENT CENSUS	475,523	8	111,765	36,036	16,353	7
8	23	SEMINARS	PATIENT CENSUS	475,523	8	5,110	69,578	748	8
9	25	TRANSPORTATION	PATIENT CENSUS	475,523	8	36,847	69,578	5,391	9
10	26	INSURANCE	PATIENT CENSUS	475,523	8	9,739	69,578	1,425	10
11	27	EMPLOYEE BENEFITS	PATIENT CENSUS	475,523	8	93,769	69,578	13,720	11
12	30	DEPRECIATION (SL)	PATIENT CENSUS	475,523	8	5,805	69,578	849	12
13	32	INTEREST	PATIENT CENSUS	475,523	8	1,420	69,578	208	13
14	33	RE TAX	PATIENT CENSUS	475,523	8	5,109	69,578	748	14
15	34	OFFICE RENT	PATIENT CENSUS	475,523	8	60,000	69,578	8,779	15
16	35	EQUIPMENT RENT	PATIENT CENSUS	475,523	8	18,286	69,578	2,676	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,153,982	\$ 424,618	\$ 168,850	25

Facility Name & ID Number WESTMONT NURSING & REHAB CTR

0050120

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization WEISS MANAGEMENT GROUP
 Street Address 6865 N LINCOLN AVE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS		\$	\$		\$	1
2	10	NURSING SALARIES	CENSUS DAYS						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	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	RELATED PARTY: WESTMONT REAL ESTATE, LLC						\$	\$		\$	1						
2	CAMBRIDGE REALTY	X		MORTGAGE	\$67,995.96	01/31/12	10,881,400	10,505,292	12/01/41	3.7500	397,554						
3	LOAN COSTS	X		AMORTIZE OVER LIFE OF LOAN			111,802	104,119			3,748						
4											4						
5											5						
Working Capital																	
6	MB FINANCIAL	X		WORKING CAPITAL	DEMAND	09/05/08	2,000,000	800,000		PRIME+	30,028						
7	F & M WEISS	X		WORKING CAPITAL	\$11,602.93	11/01/11	393,000	102,707	10/01/14	4.0000	6,991						
8	RELATED PARTY ALLOCATION										1,001						
9	TOTAL Facility Related				\$67,995.96		\$ 13,386,202	\$ 11,512,118			\$ 439,322						
B. Non-Facility Related*																	
10	GOODWILL		X	GOODWILL	\$42,088.99	09/08	7,500,000	5,836,478	09/33	6.0000	355,107						
11											11						
12											12						
13											13						
14	TOTAL Non-Facility Related				\$42,088.99		\$ 7,500,000	\$ 5,836,478			\$ 355,107						
15	TOTALS (line 9+line14)						\$ 20,886,202	\$ 17,348,596			\$ 794,429						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 52,833 Line # 36

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.		\$	92,164		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.)		\$	96,000		2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,836		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	96,960		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.		\$	100,796		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	111,229	8		
	2009	114,871	9		
	2010	118,900	10		
	2011	91,252	11		
	2012	96,000	12		
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 2012 TAX BILL.					
				FOR BHF USE ONLY	
				13	13
				FROM R. E. TAX STATEMENT FOR 2012 \$	
				14	14
				PLUS APPEAL COST FROM LINE 5 \$	
				15	15
				LESS REFUND FROM LINE 6 \$	
				16	16
				AMOUNT TO USE FOR RATE CALCULATION \$	

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTMONT NURSING & REHAB CTR COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0050120

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-22-101-001</u>	<u>NURSING HOME</u>	\$ <u>81,534.62</u>	\$ <u>81,534.62</u>
2. <u>09-22-101-002</u>	<u>NURSING HOME</u>	\$ <u>5,999.28</u>	\$ <u>5,999.28</u>
3. <u>09-22-101-003</u>	<u>NURSING HOME</u>	\$ <u>8,466.18</u>	\$ <u>8,466.18</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>96,000.08</u></u>	\$ <u><u>96,000.08</u></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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number WESTMONT NURSING & REHAB CTR

0050120

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	\$ 2,400,778	4
5										5
6										6
7										7
8	RELATED PARTY ALLOCATIONS				2,066		2,066			8
	Improvement Type**									
9	FLOORING		1986	41,641		19			41,641	9
10	ROOF & WATER LINE		1987	31,143		20			31,143	10
11	IMPROVEMENTS		1988	44,614		31.5	1,416	1,416	36,103	11
12	IMPROVEMENTS		1989	40,935		31.5	1,299	1,299	31,767	12
13	DRIVEWAY		1989	17,137		15			17,137	13
14	IMPROVEMENTS		1990	37,367		31.5	1,186	1,186	27,820	14
15	IMPROVEMENTS		1991	45,002		31.5	1,428	1,428	31,891	15
16	IMPROVEMENTS		1992	49,649		31.5	1,577	1,577	33,812	16
17	ROOF TOP A/C UNITS		1993	9,100		31.5	289	289	6,045	17
18	IMPROVEMENTS		1993	53,243		39	1,366	1,366	27,853	18
19	IMPROVEMENTS		1994	31,230		39	801	801	15,736	19
20	FLOOR COVERING		1995	795		15			795	20
21	HAND RAIL		1995	2,249		39	58	58	1,095	21
22	FLOOR TILES		1995	5,471		39	140	140	2,608	22
23	WINDOW A/C UNITS		1995	14,146		39	363	363	6,699	23
24	ARJO TUB & ATTACHED PLUMBING		1995	12,056		39	309	309	5,730	24
25	ALARM		1995	1,337		39	34	34	628	25
26	LAUNDRY BUILDING		1995	35,000		39	897	897	16,408	26
27	ROOF		1995	5,520		39	142	142	2,597	27
28	WINDOWS		1995	9,478		39	243	243	4,425	28
29	DOOR EDGE & DOOR FRAME		1996	2,099		39	54	54	970	29
30	LAUNDRY BUILDING		1996	175,187		39	4,491	4,491	78,790	30
31	AIR COOLERS		1996	6,642		39	171	171	2,990	31
32	RACING CAGE		1996	3,987		39	102	102	1,789	32
33	HAND RAIL		1996	1,156		39	30	30	521	33
34	WINDOWS		1996	11,496		39	295	295	5,126	34
35	TACK ROOM		1996	2,139		39	55	55	951	35
36	NEW CONFERENCE ROOM TILE		1997	2,938		39	76	76	1,238	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 & REHAB CTR

0050120

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALL DIETARY DOOR	1997	\$ 1,478	\$	39	\$ 38	\$ 38	\$ 619	37
38	NURSING STATION - 2ND FLOOR	1997	5,397		39	138	138	2,226	38
39	WINDON-NURSING OFFICE	1997	1,382		39	35	35	564	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107		39	28	28	475	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927		39	126	126	1,980	41
42	THE PARKING LOT	1998	42,711		15	2,990	2,990	44,658	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223		39	160	160	2,543	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715		39	326	326	4,931	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473		39	269	269	4,024	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452		39	89	89	1,309	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495		39	38	38	559	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877		39	74	74	1,082	48
49	REMODELING F WING SHOWER ROOM	1999	8,988		39	230	230	3,345	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370		39	61	61	882	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760		39	71	71	1,009	51
52	WATER HEATER - DIETARY	1999	2,931		39	75	75	1,059	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073		39	79	79	1,116	53
54	TILE - DINING ROOM	1999	1,212		39	31	31	438	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200		39	185	185	2,613	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738		39	70	70	983	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265		20	163	163	2,282	57
58	WATER HEATER - DIETARY	2000	3,573		27.5	130	130	1,728	58
59	GENERAL CONSTRUCTION	2000	27,448		27.5	998	998	13,182	59
60	ROOF REPAIR	2000	4,200		27.5	153	153	2,021	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910		27.5	106	106	1,382	61
62	NEW A/C UNIT ROOF TOP	2000	4,694		27.5	171	171	2,230	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523		20	4,026	4,026	56,364	63
64	SHOWER ROOM RENOVATIONS	2001	30,586		27.5	1,112	1,112	14,225	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341		27.5	3,903	3,903	48,300	65
66	WATER HEATER - LAUNDRY	2001	9,108		27.5	331	331	3,986	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464		27.5	453	453	5,455	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861		20	13,543	13,543	176,059	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114		20	1,456	1,456	17,472	69
70	TOTAL (lines 4 thru 69)		\$ 6,386,654	\$ 129,817		\$ 178,297	\$ 48,480	\$ 3,256,187	70

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

Facility Name & ID Number WESTMONT NURSING & REHAB CTR

0050120

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 129,817		\$ 178,297	\$ 48,480	\$ 3,256,187	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997		15	600	600	6,780	2
3	SHOWER ROOM	2002	30,924		27.5	1,125	1,125	12,609	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010		27.5	328	328	3,622	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891		27.5	541	541	5,974	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056		20	2,003	2,003	24,036	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499		20	575	575	6,900	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767		27.5	464	464	4,853	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152		27.5	1,133	1,133	11,849	9
10	THERAPY ROOM-FLOORING	2003	87,509		27.5	3,182	3,182	33,278	10
11	CONFERENCE ROOM-FLOORING	2003	2,073		27.5	76	76	795	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421		27.5	270	270	2,554	12
13	TONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825		27.5	3,266	3,266	30,347	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925		27.5	1,852	1,852	17,054	14
15	RESIDENT ROOMS-FLOORING	2005	9,821		27.5	357	357	3,109	15
16	INSTALL CABLING SYSTEM	2005	46,771		27.5	1,701	1,701	14,671	16
17	INSTALL TWO AUTOMATIC SLIDING DOOR	2005	28,000		27.5	1,018	1,018	8,186	17
18	1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE	2005	58,286		20	2,914	2,914	26,226	18
19	INSTALL DOORS - F WING, RESIDENT ROOMS	2006	4,260		27.5	155	155	1,221	19
20	WALLCOVERING, FLOORING - 1ST FLOOR CORRID	2006	63,838		27.5	2,321	2,321	18,084	20
21	AIR CONDITIONS	2006	7,968		27.5	289	289	2,163	21
22	REPLACEMENT WALK - IN FREEZER DOOR	2006	4,652		27.5	169	169	1,275	22
23	REPLACEMENT OF KITCHEN TILES	2007	13,200		27.5	380	380	2,660	23
24									24
25	WESTMONT REAL ESTATE, LLC								25
26	NEW PARKING LOT	2007	206,876	13,792	15	13,792		86,250	26
27	RESIDENT ROOMS-FLOORING, WINGS B,C,D,E,F	2007	235,801	8,575	27.5	8,575		55,380	27
28	RESIDENT ROOMS-PAINTING, WINGS B,C,D,E,F	2007	84,360		5			84,360	28
29	INSTALL NEW FIRE DOORS IN EXIST. FRAME E WING	2007	3,108	113	27.5	113		730	29
30	TUCKPOINTING, AIR CONDITIONS, WATER HEATER	2007	18,594		5			18,594	30
31	INSTALLATION OF RAILLING ON EXTERIOR STAIRS	2007	6,407	233	27.5	233		1,504	31
32	REPLACE EXISTING RECEIVING DR/FRAME/HARDWARE	2007	3,108	113	27.5	113		730	32
33	AIR CONDITIONS	2008	12,661	365	5	365		12,661	33
34	TOTAL (lines 1 thru 33)		\$ 7,591,414	\$ 153,008		\$ 226,207	\$ 73,199	\$ 3,754,642	34

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

Facility Name & ID Number WESTMONT NURSING & REHAB CTR

0050120

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12B, Carried Forward		\$ 7,591,414	\$ 153,008		\$ 226,207	\$ 73,199	\$ 3,754,642	1
2	FLAT WORK OF CONCRETE	2008	3,640	132	27.5	132		720	2
3	DINING ROOM - INSTALLATION OF DOOR	2008	2,869	105	27.5	105		573	3
4	A WING DOUDLE EGRESS FIRE	2008	2,948	107	27.5	107		585	4
5	2ND FLOOR CORRIDOR-CARPET, WALLCOVERING	2009	103,122	11,880	5	11,880		97,182	5
6	WALL AIR CONDITIONS	2009	9,397	541	5	541		9,126	6
7	1ST FLOOR RESIDENT ROOMS-WINDOW TREATMENTS	2009	16,265	1,874	5	1,874		15,329	7
8	INSTALLATION OF SIGNAGE	2009	8,020	535	15	535		2,274	8
9	EMPLOYEES BREAKROOM-PAINTING, LIGHTING	2009	2,371	86	27.5	86		412	9
10	INSTALLATION OF CAT CABLES SYSTEM	2009	3,825	139	27.5	139		666	10
11	INSTALL PANIC BARS ON DINING ROOM ENTRY DOORS	2009	5,362	195	27.5	195		935	11
12	WALL AIR CONDITIONS	2010	7,612	357	5	357		7,077	12
13	1ST FLOOR DINING ROOM-WALLCOVERING, BLINDS	2010	19,660	2,265	5	2,265		16,263	13
14	A-WING RESIDENT ROOM-BUIT-IN WARDROBES	2010	11,222	408	27.5	408		1,326	14
15	INSTALLED NEW FUEL TANK & PIPING TO ENGINE LINES	2010	6,374	232	27.5	232		754	15
16	1ST FLOOR DINING ROOM.MEDICAL RECORDS,2ND FLOOR								16
17	DINING ROOM,ACTIVITY ROOM,BEAUTY SHOP, UTILITY								17
18	ROOM-FLOORING. WINDOW TREATMENTS	2011	19,818	3,805	5	3,805		14,111	18
19	INSTALL WATER HEATER	2011	11,585	421	27.5	421		1,175	19
20	INSTALL FOUR DELAYED EGRESS LOCKS FOR 2ND FLOOR	2011	6,150	224	27.5	224		607	20
21	INSTALL FIRE ALARM SMOKE, HEATS, AV DEVCIE	2011	85,377	3,105	27.5	3,105		8,151	21
22	1ST & 2ND FLOOR DINING ROOMS-CHAIR RAIL	2011	14,720	535	27.5	535		1,315	22
23	INSTALL NEW EXHAUST VENT	2011	2,508	91	27.5	91		216	23
24	INSTALL NEW CONTROLLER & ANNUNCIATER	2011	9,245	336	27.5	336		686	24
25	INSTALL ACCUTECH SYSTEM FOR FRONT DOOR	2012	4,814	175	27.5	175		328	25
26	DELAYED EGRESS LOCKING SYSTEM FOR 1ST FLOOR	2012	12,600	458	27.5	458		821	26
27	ROOM F-16 -INSTALL NEW PVT & COVE BASE	2012	5,316	193	27.5	193		281	27
28	PLASTER, PRIME & PAINT ALL ROOMS & BATH	2012	10,631	387	27.5	387		500	28
29	WEST PARKING LOT-SEALCOAT, CRACK FILLING,								29
30	STRIPING, ASPHALTING	2013	4,460	173	15	173		173	30
31	EMPLOYEE ENTRANCE DOOR & FRAME REPLACEMENT	2013	3,254	25	27.5	25		25	31
32	2ND FLOOR CORRIDOR-CEILINGS ; REMODEL MEN BATH								32
33	ROOM ON THE 1ST FLOOR: TILE, VANITY, FAUSET	2013	15,433	70	27.5	70		70	33
34	TOTAL (lines 1 thru 33)		\$ 8,000,012	\$ 181,862		\$ 255,061	\$ 73,199	\$ 3,936,323	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,000,012	\$ 181,862		\$ 255,061	\$ 73,199	\$ 3,936,323	1
2	1ST & 2ND FLOOR LOBBY, FRONT CORRIDOR,RESIDENT								2
3	CORRIDORS: FLOORING,WALLCOVERING,PAINTING	2013	124,977	2,462	27.5	2,462		2,462	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	TOTAL (lines 1 thru 33)		\$ 8,124,989	\$ 184,324		\$ 257,523	\$ 73,199	\$ 3,938,785	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 226,792	\$ 5,499	\$ 24,142	\$ 18,643	3-10	\$ 164,750	71
72	Current Year Purchases	61,831	37,099	3,410	(33,689)	8-10	3,410	72
73	Fully Depreciated Assets	904,584					904,584	73
74	RELATED PARTY SL DEPRECIATION		10,836	10,836				74
75	TOTALS	\$ 1,193,207	\$ 53,434	\$ 38,388	\$ (15,046)		\$ 1,072,744	75

D. Vehicle Costs. (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)	\$ 10,078,022	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 237,758	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 295,911	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 58,153	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,011,529	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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

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: \$ 54,978 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>2011 FORD SHUTTLE</u>	\$ <u>#####</u>	\$ <u>14,781</u>	17
18		<u>BUS</u>			18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>14,781</u>	21

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

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

Facility Name & ID Number WESTMONT NURSING & REHAB CTR # 0050120 Report Period Beginning: 01/01/2013 Ending: 12/31/2013
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>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		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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 582,444	\$		\$ 582,444	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			223,229			223,229	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			619,757			619,757	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				228,969		228,969	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					10,862		10,862	12
13	Other (specify): MEDICAL SUPPLY	39-2					30,420		30,420	13
14	TOTAL			\$		\$ 1,425,430	\$ 270,251		\$ 1,695,681	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 & REHAB CTR**

0050120

Report Period Beginning: **01/01/2013**

Ending: **12/31/2013**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2013** (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	\$ (194,799)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,710,691		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	150,522		6
7	Other Prepaid Expenses	10,303		7
8	Accounts Receivable (owners or related parties)	477,109		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,153,826	\$	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	96,200		16
17	Accumulated Depreciation (book methods)	(63,220)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec GOODWILL)	7,500,000		22
23	Other(specify): AMORT OF GOODWILL	(2,666,667)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,866,313	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,020,139	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 465,359	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,531		28
29	Short-Term Notes Payable	800,000		29
30	Accrued Salaries Payable	281,781		30
31	Accrued Taxes Payable (excluding real estate taxes)	49,322		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,597,993	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	5,939,185		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)	\$ 5,939,185	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,537,178	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,482,961	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,020,139	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,601,337	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,601,337	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	431,624	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)	\$ (118,376)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,482,961	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 14,231,482	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,231,482	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	1,000	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)	\$ 1,000	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	131,786	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 131,786	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COMPUTER INCOME	74,250	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 74,250	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,438,518	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,003,267	31
32	Health Care	4,914,487	32
33	General Administration	3,040,398	33
B. Capital Expense			
34	Ownership	1,852,568	34
C. Ancillary Expense			
35	Special Cost Centers	1,695,681	35
36	Provider Participation Fee	487,742	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES-ARCHITECTS FEE	12,751	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,006,894	40
41	Income before Income Taxes (line 30 minus line 40)**	431,624	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 431,624	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,886,506	44
45	Private Pay - Net Inpatient Revenue	1,665,803	45
46	Medicare - Net Inpatient Revenue	5,434,001	46
47	Other-(specify) VETERAN	49,834	47
48	Other-(specify) INSURANCE	195,338	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,231,482	49

****TAX RETURN PREPARED ON CASH BASIS**

* 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.

*** 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 & REHAB CTR**

0050120

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

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	2,040	2,080	\$ 123,642	\$ 59.44	1
2	Assistant Director of Nursing	2,824	3,088	126,654	41.01	2
3	Registered Nurses	28,599	30,458	908,954	29.84	3
4	Licensed Practical Nurses	34,406	35,616	934,206	26.23	4
5	CNAs & Orderlies	124,064	129,018	1,413,366	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,261	13,502	203,320	15.06	8
9	Activity Director	1,080	1,193	21,658	18.15	9
10	Activity Assistants	15,797	16,618	154,698	9.31	10
11	Social Service Workers	8,558	8,688	140,632	16.19	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,080	37,516	18.04	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,581	31,654	306,654	9.69	15
16	Dishwashers					16
17	Maintenance Workers	5,864	6,376	92,498	14.51	17
18	Housekeepers	37,779	40,165	375,333	9.34	18
19	Laundry	5,276	5,371	46,958	8.74	19
20	Administrator	1,872	2,088	152,202	72.89	20
21	Assistant Administrator	480	480	6,937	14.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,451	18,960	314,915	16.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,652	2,929	32,697	11.16	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,436	8,126	106,041	13.05	31
32	Other Health C: <u>MDS COORD</u>	6,056	6,408	207,938	32.45	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	346,092	364,898	\$ 5,706,819 *	\$ 15.64	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly fees \$ 22,735	1-3	35
36	Medical Director	Monthly fees 54,810	9-3	36
37	Medical Records Consultant	12 660	10-3	37
38	Nurse Consultant	Monthly fees 139,698	10-3	38
39	Pharmacist Consultant	Monthly fees 3,447	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	19 1,190	11-3	44
45	Social Service Consultant	24 1,449	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	55 \$ 223,989		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
BENJAMIN FRIEDMAN	ADMINISTRATOR	0	\$ 139,279	Workers' Compensation Insurance	\$ 161,792	IDPH License Fee	\$ 1,990	
JOSH LEGUM	ADMINISTRATOR	0	12,923	Unemployment Compensation Insurance	117,625	Advertising: Employee Recruitment	771	
ANZHELIKA SHATROVA	ASST ADMIN	0	6,937	FICA Taxes	428,817	Health Care Worker Background Check	1,280	
				Employee Health Insurance	124,013	(Indicate # of checks performed 32)		
				Employee Meals	0	Patient Background Checks	2	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	7,815	
				EMPLOYEE BENEFITS - OTHER	117,389	MARKETING/ADV/PROMO	67,940	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	20,392	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	6,779	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(7,815)	
				INSURANCE - EXECUTIVE LIFE	8,881	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	(8,881)	Non-allowable advertising	(67,940)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 159,139	TOTAL (agree to Schedule V, line 22, col.8)	\$ 949,636	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 31,412	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
DA WESTMONT	MANAGEMENT FEES		\$ 810,000				Out-of-State Travel	\$
							In-State Travel	0
							Seminar Expense	0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 810,000	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			164,076					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 164,076					

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8						N/A						
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number WESTMONT NURSING & REHAB CTR

0050120

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 \$ 13,099
- (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. \$ 53,190 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 YES. 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. \$ 487,742
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.