FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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.

I. IDPH License ID Number: 0049643

Facility Name: Manorcare of Westmont

Address: 512 East Ogden Avenue (Number) Westmont (City) 60559 (Zip Code)

County: Du Page

Telephone Number: (630) 323-4400 **Fax #** (630) 323-4583

HFS ID Number:

Date of Initial License for Current Owners: 05/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Gary Geise **Telephone Number:** (419) 252-5731
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/09 to 5/31/10 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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**

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,838	10,790	21,177	45,805	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,838	10,790	21,177	45,805	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.96%

D. How many bed-hold days during this year were paid by the Department?
8 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 05/01/77

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 155 and days of care provided 17,098

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

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

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

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	388,360	26,381	2,657	417,398	11,834	429,232		429,232			1
2	Food Purchase		336,110		336,110		336,110	(3,007)	333,103			2
3	Housekeeping	234,885	35,877	2,300	273,062		273,062		273,062			3
4	Laundry	40,995	21,345	1,386	63,726		63,726		63,726			4
5	Heat and Other Utilities			282,598	282,598	3,293	285,891		285,891			5
6	Maintenance	52,404	31,325	95,639	179,368		179,368		179,368			6
7	Other (specify):* Med Waste			7,232	7,232		7,232		7,232			7
8	**TOTAL General Services**	716,644	451,038	391,812	1,559,494	15,127	1,574,621	(3,007)	1,571,614			8
	B. Health Care and Programs											
9	Medical Director			18,781	18,781		18,781		18,781			9
10	Nursing and Medical Records	4,348,133	332,399	75,189	4,755,721	4,347	4,760,068		4,760,068			10
10a	Therapy	1,486,134	14,395	75,306	1,575,835		1,575,835		1,575,835			10a
11	Activities	130,158	13,894	1,854	145,906		145,906		145,906			11
12	Social Services	202,750	609	413	203,772		203,772		203,772			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,167,175	361,297	171,543	6,700,015	4,347	6,704,362		6,704,362			16
	C. General Administration											
17	Administrative	91,238		562,119	653,357	(143,990)	509,367		509,367			17
18	Directors Fees											18
19	Professional Services			45,634	45,634		45,634	(45,634)				19
20	Dues, Fees, Subscriptions & Promotions			65,743	65,743		65,743	(40,103)	25,640			20
21	Clerical & General Office Expenses	410,985	65,115	240,339	716,439		716,439	(92,243)	624,196			21
22	Employee Benefits & Payroll Taxes			1,184,384	1,184,384	98,247	1,282,631		1,282,631			22
23	Inservice Training & Education			5,723	5,723		5,723		5,723			23
24	Travel and Seminar			5,705	5,705		5,705		5,705			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			381,514	381,514		381,514		381,514			26
27	Other (specify):*											27
28	**TOTAL General Administration**	502,223	65,115	2,491,161	3,058,499	(45,743)	3,012,756	(177,980)	2,834,776			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,386,042	877,450	3,054,516	11,318,008	(26,269)	11,291,739	(180,987)	11,110,752			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare of Westmont #0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			506,566	506,566	26,269	532,835		532,835			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			117,624	117,624		117,624		117,624			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			120,253	120,253		120,253		120,253			35
36	Other (specify):*											36
37	TOTAL Ownership			744,443	744,443	26,269	770,712		770,712			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		803,022		803,022		803,022		803,022			39
40	Barber and Beauty Shops			15,007	15,007		15,007		15,007			40
41	Coffee and Gift Shops	806			806		806		806			41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):* IV Ther, X-Ray & Lab		84,381	126,380	210,761		210,761		210,761			43
44	TOTAL Special Cost Centers	806	887,403	226,250	1,114,459		1,114,459		1,114,459			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,386,848	1,764,853	4,025,209	13,176,910		13,176,910	(180,987)	12,995,923			45

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

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,007)	2		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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(389)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,731)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(45,634)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(87,583)	21		24
25	Fund Raising, Advertising and Promotional	(40,103)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,540)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (180,987)		$	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 Amount	2 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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (180,987)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Manorcare of Westmont

ID# 0049643

Report Period Beginning: 06/01/09

Ending: 5/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,496)	21	1
2	Miscellaneous Income	(44)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,540)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Westmont # 0049643 **Report Period Beginning:** 06/01/09 **Ending:** 5/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,007)	0	0	0	0	0	0	0	0	0	0	(3,007)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,007)	0	0	0	0	0	0	0	0	0	0	(3,007)	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	(45,634)	0	0	0	0	0	0	0	0	0	0	(45,634)	19
20	Fees, Subscriptions & Promotions	(40,103)	0	0	0	0	0	0	0	0	0	0	(40,103)	20
21	Clerical & General Office Expenses	(92,243)	0	0	0	0	0	0	0	0	0	0	(92,243)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(177,980)	0	0	0	0	0	0	0	0	0	0	(177,980)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(180,987)	0	0	0	0	0	0	0	0	0	0	(180,987)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Westmont # 0049643 **Report Period Beginning:** 06/01/09 **Ending:** 5/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(180,987)	0	0	0	0	0	0	0	0	0	0	(180,987)	45

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

VII. RELATED PARTIES

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

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

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

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

1 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	See Pg 8	Home Office Allocation	$ 562,119	HCR Manor Care, Inc.	100.00%	$ 562,119	$	1
2	V								2
3	V								3
4	V	10a	Therapy Management	43,198	Heartland Management Services	100.00%	43,198		4
5	V								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			$ 605,317			$ 605,317	$ *	14

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

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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

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

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

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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 [X] NO [ ]

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

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

	1 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	1	Dietary - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	$ 2,826,629	$ 1,585,087	11,964,064	$ 11,834	1
2	1	Dietary - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			11,964,064	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs,HHs, Rehab			11,964,064	0	3
4	5	Utilities - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs			11,964,064	0	4
5	5	Utilities - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			11,964,064	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	911,333		11,964,064	3,293	6
7	10	Nursing - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	632,689	715,152	11,964,064	2,649	7
8	10	Nursing - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			11,964,064	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	469,810		11,964,064	1,698	9
10	17	Gen/Admin - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	35,518,981		11,964,064	148,700	10
11	17	Gen/Admin - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	1,045,204		11,964,064	18,089	11
12	17	Gen/Admin - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	69,554,530	79,745,671	11,964,064	251,340	12
13	22	Empl Bnfts -Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	6,239,311		11,964,064	26,121	13
14	22	Empl Bnfts -Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	2,434,366		11,964,064	42,132	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	8,300,418		11,964,064	29,994	15
16	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	102,714		11,964,064	430	16
17	30	Deprec - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	43,612		11,964,064	755	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	6,941,685		11,964,064	25,084	18
19										19
20	32	Directly Assigned Interest				21,122,019				20
21		Non Central Div Nrsg Hm				25,797,439				21
22										22
23										23
24										24
25	TOTALS					$ 181,940,740	$ 82,045,910		$ 562,119	25

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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

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

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

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

Facility Name & ID Number Manorcare of Westmont # 0049643 **Report Period Beginning:** 06/01/09 **Ending:** 5/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 103,794	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.)		$ 114,451	2
3. Under or (over) accrual (line 2 minus line 1).		$ 10,657	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 106,967	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.		$ 117,624	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	102,582	8
2006	111,078	9
2007	107,564	10
2008	112,209	11
2009	116,692	12

Line 2: $114,450.51 = $58,345.78 for 1st half of 2009 + $56,104.73 for 2nd half of 2008

Line 4: $106,967 = $48,621.48 for Jan-May 2010 + $58,345.78 2nd half 2009

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Westmont COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0049643

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-03-207-014	See Attached	$ 116,691.56	$ 116,691.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 116,691.56	$ 116,691.56

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1977	$ 195,699	1
2			2004	33,809	2
3	TOTALS			$ 229,508	3

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1977	$ 1,372,073	$ 80,681		$ 80,681	$	$ 1,418,781	4
5				2004	1,903,806						5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					266,475		266,475		3,544,123	9
10				1985	42,165						10
11				1986	9,808						11
12				1987	118,541						12
13				1988	118,593						13
14				1989	58,768						14
15				1990	15,910						15
16				1991	58,674						16
17				1992	84,338						17
18				1993	50,656						18
19				1994	697,677						19
20				1995	184,192						20
21				1996	118,190						21
22				1997	90,456						22
23				1998	253,224						23
24				1999	3,181						24
25				2000	85,888						25
26				2001	224,426						26
27	VINYL WALLCOVERING			2002	1,404						27
28	WINDOW TREATMENTS			2002	907						28
29	PAINT, WVC, & CARPET			2002	8,512						29
30	INSTALL PHONE JACKS			2002	476						30
31	ELECTRIC WORK & FIXTURES			2002	2,699						31
32	CONSTRUCTION OF NEW INTERIOR WALL			2002	1,930						32
33	CONCRETE / RETAINING WALL			2002	11,871						33
34	STORAGE ROOM			2003	6,740						34
35	VINYL WALLCOVERING			2003	7,131						35
36	Carpet			2003	1,744						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	CONSTRUCTION DEPT. COST & INTEREST	2003	$ 3,554	$		$	$	$	37
38	WALLCOVERING & CARPET	2003	16,639						38
39	CABINETRY - CUSTON MADE & INSTALLED	2003	4,875						39
40	WINDOWS INSTALLED & EXTEND WALL	2003	14,827						40
41	BIFOLD OPERATOR DOOR	2003	2,446						41
42	WALLCOVERING & CARPET	2004	2,250						42
43	General Build Overhead & Interest	2004	117,867						43
44	Carpentry	2004	26,990						44
45	Mill Work	2004	4,207						45
46	Doors & Frames	2004	24,238						46
47	Windows	2004	10,470						47
48	Flooring	2004	1,012						48
49	Wallcovering & Corner Guards	2004	99,668						49
50	Fire Sprinkler System	2004	800						50
51	Plumbing	2004	1,626						51
52	Electrical	2004	4,889						52
53	Bldg Addtn - Architect, Engineering, Permits, Plan Reviews	2004	223,090						53
54	Bldg Addtn - General Overhead Costs & Interest	2004	616,107						54
55	Bldg Addtn - Carpeting	2004	21,109						55
56	Bldg Addtn - Wallcovering & Corner Guards	2004	25,299						56
57	Bldg Addtn - Millwork	2004	11,524						57
58	Bldg Addtn - Soil & Concrete Testing, Water & Sewer Fees	2004	108,430						58
59	Bldg Addtn - Land Prep/Improvements for Construction	2004	284,371						59
60	Bldg Addtn - Paving	2004	57,718						60
61	Garage Renov. - Roof, Decking, Door, Siding, Soffits	2004	9,820						61
62	Doors	2004	13,114						62
63	Repair Wall & VWC	2004	7,292						63
64	Door Hardware	2005	5,800						64
65	fire caulking	2005	13,665						65
66	Additional cost for caulking	2005	1,765						66
67	New Door	2005	1,694						67
68	Feed for Door Operator	2005	550						68
69	New Doors	2005	8,861						69
70	TOTAL (lines 4 thru 69)		$ 7,280,547	$ 347,156		$ 347,156	$	$ 4,962,904	70

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

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12A, Carried Forward		$ 7,280,547	$ 347,156		$ 347,156	$	$ 4,962,904	1
2	Doors	2005	3,179						2
3	Service Doors	2005	3,179						3
4	Renov - Genreal Overhead & interest	2005	26,091						4
5	Renov - Resilient Flooring	2005	90,087						5
6	Renov - Wallcovering	2005	5,644						6
7	Renov - Carpentry - Supbcontr	2005	10,000						7
8	Renov - Fire Sprinkler System	2005	4,125						8
9	Renov - Wood Doors & Frames	2005	22,840						9
10	Renov - Accoustical Ceiling Tiles	2005	2,500						10
11	New Door & Thresholds	2006	3,200						11
12	Vinyl Covering & Flooring	2005	2,971						12
13	Doors	2006	1,066						13
14	Light poles & base	2005	3,300						14
15	Doors cost adjustment /duplicate	2005	(3,179)						15
16	Renov - general overhead & interest	2006	11,813						16
17	Renov - basic electrical - elevator	2006	60,598						17
18	countertop	2006	1,040						18
19	120V feed	2006	1,118						19
20	ductwork	2006	4,930						20
21	40 beds / assist rails	2006	11,328						21
22	2 resident room doors	2007	1,400						22
23	5 resident room doors	2007	6,300						23
24	5 doors in Resident rooms	2007	2,475						24
25	electrical for steamer	2007	1,629						25
26	13 windows	2007	14,105						26
27	flooring in shower room	2007	6,440						27
28	metal doors	2007	5,379						28
29	Resident Room Doors	2008	7,910						29
30	Parking improvements Prelim site layout	2008	1,250						30
31	Renov - Landscaping Front Entrance	2008	38,406						31
32	Renov - Landscaping General overhead & interest	2008	1,090						32
33	RTU	2008	8,141						33
34	TOTAL (lines 1 thru 33)		$ 7,640,903	$ 347,156		$ 347,156	$	$ 4,962,904	34

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

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12B, Carried Forward		$ 7,640,903	$ 347,156		$ 347,156	$	$ 4,962,904	1
2	CO2 System	2008	5,965						2
3	Insulation for RTU	2008	3,445						3
4	Renov - Restrooms- gen overhead & interest	2008	8,867						4
5	Renov - Restrooms - Resilient flooring	2008	10,915						5
6	Renov Restrooms - Wallcovering	2008	7,401						6
7	Renov - Restrooms -HVAC	2008	3,710						7
8	Central Bath Ceramic Tile	2007	4,271						8
9	Renov - Patio & Grill-Gen Overhead & Interest	2008	4,886						9
10	Renov - Patio & Grill addition	2008	35,629						10
11	Stainless Steel Drain	2009	4,545						11
12	Sprinkler head in kitchen	2009	10,720						12
13	2 water meters for kitchen	2009	6,296						13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,747,553	$ 347,156		$ 347,156	$	$ 4,962,904	34

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

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,488,581	$ 159,410	$ 159,410	$		$ 1,945,994	71
72	Current Year Purchases	74,566						72
73	Fully Depreciated Assets							73
74	Home Office & Retirements			26,269	26,269			74
75	TOTALS	$ 2,563,147	$ 159,410	$ 185,679	$ 26,269		$ 1,945,994	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,540,208	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 506,566	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 532,835	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,269	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,908,898	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.

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] 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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 120,253 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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 Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	7862 hrs	$ 318,564	284	$ 15,680	$ 4,937	8,146	$ 339,181	1
2	Licensed Speech and Language Development Therapist	10a	2631 hrs	113,691	82	4,500	203	2,713	118,394	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	7571 hrs	321,311			9,255	7,571	330,566	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				803,022		803,022	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): PS Inhal/Xray & Lab	10a & 43,3	3938	107,987			84,381	3,938	192,368	13
14	TOTAL			$ 861,553	366	$ 20,180	$ 901,798	22,368	$ 1,783,531	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.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare of Westmont **#** 0049643 **Report Period Beginning:** 06/01/09 **Ending:** 5/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 5/31/10 **(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	$ 14,915	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (373,532))	1,710,663		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,741		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,730,319	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	229,508		13
14	Buildings, at Historical Cost	7,747,553		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,563,147		16
17	Accumulated Depreciation (book methods)	(6,908,898)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	186,327		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,817,637	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,547,956	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 307,070	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	728,465		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	106,967		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	107,496		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,249,998	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	9,996		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 9,996	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,259,994	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,287,962	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,547,956	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare of Westmont # 0049643 **Report Period Beginning:** 06/01/09 **Ending:** 5/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,989,106	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,989,106	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,581,820	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,581,820	17
	B. Transfers (Itemize):		
18	**Change in interdivision**	(3,282,964)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (3,282,964)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,287,962	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,601,709	1
2	Discounts and Allowances for all Levels	(4,905,024)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,696,685	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,948,152	6
7	Oxygen	71,574	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,019,726	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	1,496	12
13	Barber and Beauty Care	17,575	13
14	Non-Patient Meals	3,007	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	848,005	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	65,986	19
20	Radiology and X-Ray	38,501	20
21	Other Medical Services	63,003	21
22	Laundry	4,652	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,042,225	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 50	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	44	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,758,730	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,559,494	31
32	Health Care	6,700,015	32
33	General Administration	3,058,499	33
	B. Capital Expense		
34	Ownership	744,443	34
	C. Ancillary Expense		
35	Special Cost Centers	1,029,596	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,176,910	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,581,820	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,581,820	43

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

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

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

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

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,042	2,221	$ 107,036	$ 48.19	1
2	Assistant Director of Nursing	1,934	2,103	78,723	37.43	2
3	Registered Nurses	52,334	56,901	1,928,560	33.89	3
4	Licensed Practical Nurses	24,449	26,583	685,392	25.78	4
5	CNAs & Orderlies	103,003	112,209	1,516,423	13.51	5
6	CNA Trainees					6
7	Licensed Therapist	23,817	26,021	1,027,091	39.47	7
8	Rehab/Therapy Aides	16,313	17,823	459,043	25.76	8
9	Activity Director	8,731	9,523	130,158	13.67	9
10	Activity Assistants					10
11	Social Service Workers	7,735	8,501	202,750	23.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,016	29,485	388,360	13.17	15
16	Dishwashers					16
17	Maintenance Workers	2,062	2,250	52,404	23.29	17
18	Housekeepers	18,655	20,354	234,885	11.54	18
19	Laundry	3,659	3,988	40,995	10.28	19
20	Administrator	2,080	2,080	91,238	43.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,779	21,216	410,985	19.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,849	2,017	31,999	15.86	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	83	90	806	8.96	33
34	TOTAL (lines 1 - 33)	315,541	343,365	$ 7,386,848 *	$ 21.51	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,781	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,159	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,940		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	(24)	$ (866)	10, 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	(24)	$ (866)		53

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Ulm	Administrator	0	$ 91,238
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 91,238

B. Administrative - Other

Description	Amount
Management Fees	$ 562,119
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 562,119

C. Professional Services

Vendor/Payee	Type	Amount
Foote, Meyers, & Flowers, LLC	Legal Fees	$ 44,243
United Collection Bureau Inc	Accounting Fees	1,391
Legal fees were adjusted off on Schedule VI, Page 5, Line 22. Therefore, no legal invoices are attached.		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 45,634

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,742
Unemployment Compensation Insurance	59,790
FICA Taxes	525,574
Employee Health Insurance	360,853
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	
4101K	75,870
Oth Employee Benefits	9,984
Tuition Program	1,375
SMSP Match	
Employee Uniforms	5,196
Home Office Allocation	98,247
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,282,631

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 7,048
Advertising: Employee Recruitment	6,174
Health Care Worker Background Check (Indicate # of checks performed 176)	2,113
Patient Background Checks 200	2,000
Dues & Subscriptions	2,642
Association Dues	12,318
Advertising	33,448
Public Relations	
Less: Non-allowable Assn Dues	(6,655)
Less: Public Relations Expense	(0)
Non-allowable advertising	(33,448)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,640

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,705
Includes travel expense to the Home Office in Toledo, OH for regional meetings.	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,705

**See instructions.

Facility Name & ID Number Manorcare of Westmont # 0049643 Report Period Beginning: 06/01/09 Ending: 5/31/10

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
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18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Manorcare of Westmont** **#** **0049643** **Report Period Beginning:** **06/01/09** **Ending:** **5/31/10**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICHA $5,663**

(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 $6655**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5-10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **74,046** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **84,863**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **3,007**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **NO**
Attach invoices and a summary of services for all architect and appraisal fees.