FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0050120

Facility Name: WESTMONT NURSING AND REHAB CENTER

Address: 6501 S. CASS AVE. (Number) WESTMONT (City) 60559 (Zip Code)

County: DUPAGE

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

Date of Initial License for Current Owners: 09/03/08

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
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 01/01/2010 to 12/31/2010 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) AVRUM WEINFELD
(Title) CEO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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 WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,035	1,695	12,999	23,729	8
9	SNF/PED					9
10	ICF	40,547	8,903	87	49,537	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,582	10,598	13,086	73,266	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.36%

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 [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 09/03/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/03/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 125 and days of care provided 9,072

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CEN # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	310,274	35,570	700	346,544		346,544		346,544			1
2	Food Purchase		372,705		372,705		372,705	(1,383)	371,322			2
3	Housekeeping	461,364	82,424		543,788		543,788		543,788			3
4	Laundry	74,105	27,019	5,794	106,918		106,918		106,918			4
5	Heat and Other Utilities			275,624	275,624		275,624	458	276,082			5
6	Maintenance	108,171	66,393	32,330	206,894		206,894	1,674	208,568			6
7	Other (specify):*			10,568	10,568		10,568	48	10,616			7
8	**TOTAL General Services**	953,914	584,111	325,016	1,863,041		1,863,041	797	1,863,838			8
	B. Health Care and Programs											
9	Medical Director			58,000	58,000		58,000		58,000			9
10	Nursing and Medical Records	3,398,019	230,196	67,452	3,695,667		3,695,667		3,695,667			10
10a	Therapy	212,116	6,125		218,241		218,241		218,241			10a
11	Activities	145,717	2,316	1,169	149,202		149,202		149,202			11
12	Social Services	130,598		3,806	134,404		134,404		134,404			12
13	CNA Training											13
14	Program Transportation			115	115		115		115			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,886,450	238,637	130,542	4,255,629		4,255,629		4,255,629			16
	C. General Administration											
17	Administrative	204,350		957,000	1,161,350		1,161,350		1,161,350			17
18	Directors Fees											18
19	Professional Services			88,260	88,260		88,260	79	88,339			19
20	Dues, Fees, Subscriptions & Promotions			97,529	97,529		97,529	(56,526)	41,003			20
21	Clerical & General Office Expenses	359,142	44,136	47,289	450,567		450,567	(133,813)	316,754			21
22	Employee Benefits & Payroll Taxes			806,072	806,072		806,072	(8,241)	797,831			22
23	Inservice Training & Education			4,132	4,132		4,132		4,132			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			6,144	6,144		6,144		6,144			25
26	Insurance-Prop.Liab.Malpractice			230,506	230,506		230,506	94	230,600			26
27	Other (specify):*			138,586	138,586		138,586	(138,586)				27
28	**TOTAL General Administration**	563,492	44,136	2,375,518	2,983,146		2,983,146	(336,993)	2,646,153			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,403,856	866,884	2,831,076	9,101,816		9,101,816	(336,196)	8,765,620			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#: WESTMONT NURSING AND REHAB CENTER #0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		700	
			0	700
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,794	
			0	5,794
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		46,817	
	ELECTRICITY		100,967	
	WATER		110,843	
	CABLE TV - LOBBY		16,997	
			0	275,624
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		15,709	
	PAINTING & DECORATING		2,010	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		825	
	ELEVATOR MAINTENANCE & REPAIR		6,140	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,575	
	FIRE SERVICE		3,071	
			0	
			0	
			0	
			0	32,330
7	**OTHER**			
	SCAVENGER		10,568	
	SECURITY SERVICE		0	
			0	
			0	10,568
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	58,000	58,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		23,023	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,140	
	PHARMACY CONSULTANT	XVIII B 39-2	3,498	
	UTILIZATION REVIEW FEES	XVIII B __-2	1,200	
	PHYSICIANS	XVIII B __-2	5,263	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	33,328	
			0	
			0	67,452
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,169	
			0	1,169
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	44	
	SOCIAL WORKER	XVIII B 45-2	3,762	
			0	3,806
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER **#0050120** **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		115	115
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	957,000	957,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	55,725	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	32,535	
			0	88,260
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	38,072	
	EMPLOYEE WANT ADS	XIX F	21,961	
	CONTRIBUTIONS	VI 20 XIX F	10,000	
	DUES & SUBSCRIPTIONS	XIX F	12,177	
	LICENSES & PERMITS	XIX F	4,290	
	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	8,529	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,500	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				97,529
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		517	
	EQUIPMENT REPAIR & MAINTENANCE		20,075	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		26,697	
	MESSENGER SERVICE		0	
			0	47,289

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	404,574	
	UNEMPLOYMENT COMPENSATION	XIX D	52,156	
	WORKERS COMPENSATION INSURANC	XIX D	128,371	
	HOSPITALIZATION INSURANCE	XIX D	100,005	
	EMPLOYEE BENEFITS - OTHER	XIX D	112,725	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	8,241	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	806,072
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,132	
				4,132
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,144	
				6,144
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		230,506	
				230,506
27	**OTHER**			
	BAD DEBTS	VI 24	138,586	
				138,586

GRAND TOTAL COLUMN 3 OTHER **2,831,076**

WESTMONT NURSING AND REHAB CENTER
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	372,705
LESS SALES TAX	(1,383)
NET FOOD	371,322
TOTAL PATIENT CENSUS	73,266
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	219,798
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	219,798
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	219,798
NET FOOD	371,322
DIVIDE TOTAL MEALS/YEAR	219,798
COST PER MEAL	1.69
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER #0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							436,196	436,196			30
31	Amortization of Pre-Op. & Org.			500,000	500,000		500,000	(500,000)				31
32	Interest			449,027	449,027		449,027	175,381	624,408			32
33	Real Estate Taxes							120,478	120,478			33
34	Rent-Facility & Grounds			942,000	942,000		942,000	(942,000)				34
35	Rent-Equipment & Vehicles			62,097	62,097		62,097	632	62,729			35
36	Other (specify):* **OFFICE RENT**			14,835	14,835		14,835	37,760	52,595			36
37	**TOTAL Ownership**			1,967,959	1,967,959		1,967,959	(671,553)	1,296,406			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		340,943	968,951	1,309,894		1,309,894		1,309,894			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,713	117,713		117,713		117,713			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		340,943	1,086,664	1,427,607		1,427,607		1,427,607			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,403,856	1,207,827	5,885,699	12,497,382		12,497,382	(1,007,749)	11,489,633			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 WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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				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	114,714	30		9
10	Interest and Other Investment Income	(16,953)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,383)	2		13
14	Non-Care Related Interest	(449,027)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(18,529)	20		20
21	Owner or Key-Man Insurance	(8,241)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(138,586)	27		24
25	Fund Raising, Advertising and Promotional	(38,072)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(633,835)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,189,912)		$	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)	182,163		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 182,163		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,007,749)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WESTMONT NURSING AND REHAB CENTER

ID# 0050120

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	MARKETING SALARY	(133,835)	21	2
3	AMORTIZATION OF GOODWILL	(500,000)	31	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(633,835)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER **#** 0050120 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,383)	0	0	0	0	0	0	0	0	0	0	(1,383)	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	458	0	0	0	0	0	0	0	0	458	5
6	Maintenance	0	0	1,674	0	0	0	0	0	0	0	0	1,674	6
7	Other (specify):*	0	0	48	0	0	0	0	0	0	0	0	48	7
8	**TOTAL General Services**	(1,383)	0	2,180	0	0	0	0	0	0	0	0	797	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	79	0	0	0	0	0	0	0	0	79	19
20	Fees, Subscriptions & Promotions	(56,601)	0	75	0	0	0	0	0	0	0	0	(56,526)	20
21	Clerical & General Office Expenses	(133,835)	0	22	0	0	0	0	0	0	0	0	(133,813)	21
22	Employee Benefits & Payroll Taxes	(8,241)	0	0	0	0	0	0	0	0	0	0	(8,241)	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	94	0	0	0	0	0	0	0	0	94	26
27	Other (specify):*	(138,586)	0	0	0	0	0	0	0	0	0	0	(138,586)	27
28	**TOTAL General Administration**	(337,263)	0	270	0	0	0	0	0	0	0	0	(336,993)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(338,646)	0	2,450	0	0	0	0	0	0	0	0	(336,196)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	114,714	320,104	1,378	0	0	0	0	0	0	0	0	436,196	30
31	Amortization of Pre-Op. & Org.	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	31
32	Interest	(465,980)	638,977	2,384	0	0	0	0	0	0	0	0	175,381	32
33	Real Estate Taxes	0	118,550	1,928	0	0	0	0	0	0	0	0	120,478	33
34	Rent-Facility & Grounds	0	(942,000)	0	0	0	0	0	0	0	0	0	(942,000)	34
35	Rent-Equipment & Vehicles	0	0	632	0	0	0	0	0	0	0	0	632	35
36	Other (specify):*	0	52,595	(14,835)	0	0	0	0	0	0	0	0	37,760	36
37	**TOTAL Ownership**	(851,266)	188,226	(8,513)	0	0	0	0	0	0	0	0	(671,553)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,189,912)	188,226	(6,063)	0	0	0	0	0	0	0	0	(1,007,749)	45

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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	$ 942,000	WESTMONT REAL ESTATE, LLC	100.00%	$	$ (942,000)	1
2	V	30	DEPRECIATION (SL)				320,104	320,104	2
3	V	32	INTEREST				629,031	629,031	3
4	V	32	AMORT LOAN COST				9,946	9,946	4
5	V	33	REAL ESTATE TAXES				118,550	118,550	5
6	V	36	MIP INSURANCE				52,595	52,595	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 942,000			$ 1,130,226	$ * 188,226	14

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	36	OFFICE RENT	$ 14,835	IME REALTY CORP		$	$ (14,835)	15
16	V	5	UTILITIES				458	458	16
17	V	6	PAINTERS FEES				489	489	17
18	V	6	REPAIRS/MAINT				1,185	1,185	18
19	V	7	ALARM SERVICE				48	48	19
20	V	19	ACCOUNTING FEES				79	79	20
21	V	21	OFFICE EXPENSE				22	22	21
22	V	26	INSURANCE				94	94	22
23	V	30	DEPRECIATION (SL)				1,378	1,378	23
24	V	32	INTEREST				2,384	2,384	24
25	V	33	RE TAX				1,928	1,928	25
26	V	35	STORAGE FEES				632	632	26
27	V	20	LICENSES & PERMITS				75	75	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 14,835			$ 8,772	$ * (6,063)	39

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CEI # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	DANIEL WEISS	GEN. PARTNERS	ADMINISTRAT.	40.00	SEE			MGMT FEE	$ 478,500	17-3	1
2	AVRUM WEINFELD	GEN. PARTNERS	ADMINISTRAT.	40.00	ATTACHED SCHEDULES			MGMT FEE	478,500	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 957,000		13

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

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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

	1 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	5	UTILITIES	INCOME	187,059	14	$ 5,775	$	14,835	$ 458	1
2	6	PAINTERS FEES	INCOME	187,059	14	6,152		14,835	489	2
3	6	REPAIRS/MAINT	INCOME	187,059	14	14,941		14,835	1,185	3
4	7	ALARM SERVICE	INCOME	187,059	14	601		14,835	48	4
5	19	ACCOUNTING FEES	INCOME	187,059	14	998		14,835	79	5
6	21	OFFICE EXPENSE	INCOME	187,059	14	274		14,835	22	6
7	26	INSURANCE	INCOME	187,059	14	1,211		14,835	94	7
8	30	DEPRECIATION (SL)	INCOME	187,059	14	17,356		14,835	1,378	8
9	32	INTEREST	INCOME	187,059	14	30,039		14,835	2,384	9
10	33	RE TAX	INCOME	187,059	14	24,313		14,835	1,928	10
11	35	STORAGE FEES	INCOME	187,059	14	7,961		14,835	632	11
12	20	LICENSES & PERMITS	INCOME	187,059	14	971		14,835	75	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					$ 110,592	$		$ 8,772	25

Facility Name & ID Number WESTMONT NURSING AND REHAB CEN' # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	RELATED PARTY: WESTMONT REAL ESTATE, LLC						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$77,424.46	11/17/06	10,881,400	10,466,481	12/01/41	5.9800	629,031	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN			348,110	307,027			9,946	3
4												4
5	RELATED PARTY										2,384	5
	Working Capital											
6												6
7												7
8	IME REALTY ALLOCATION											8
9	TOTAL Facility Related				$77,424.46		$ 11,229,510	$ 10,773,508			$ 641,361	9
	B. Non-Facility Related*											
10	BRICKYRD BANK		X	GOODWILL	$29,590.38	09/08	1,500,000	6,333,333	09/13	6.7500	379,754	10
11	GOODWILL		X	GOODWILL	$42,088.99	09/08	7,500,000	862,716	09/33	6.0000	69,273	11
12												12
13												13
14	TOTAL Non-Facility Related				$71,679.37		$ 9,000,000	$ 7,196,049			$ 449,027	14
15	TOTALS (line 9+line14)						$ 20,229,510	$ 17,969,557			$ 1,090,388	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 52,595 **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.)**

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER **#** 0050120 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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.**	$ 112,341	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.)		$ 114,871	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,530	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 116,020	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.		$ 118,550	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	91,769	8
2006	101,943	9
2007	103,511	10
2008	111,229	11
2009	114,871	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 2009 TAX BILL.

	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 WESTMONT NURSING AND REHAB CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0050120

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 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.	09-22-101-001	NURSING HOME	$ 102,601.72	$ 102,601.72
2.	09-22-101-002	NURSING HOME	$ 5,088.48	$ 5,088.48
3.	09-22-101-003	NURSING HOME	$ 7,180.92	$ 7,180.92
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 114,871.12	$ 114,871.12

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 WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [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	NURSING HOME		1995	$ 349,103	1
2	PARKING LOT		2006	410,723	2
3	TOTALS			$ 759,826	3

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	215			1995	$ 4,982,301	$ 127,751	39	$ 127,751	$ 127,751	$ 2,017,525	4
5											5
6											6
7											7
8	IME REALTY ALLOCATIONS					1,323		1,323			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	31,855	11
12	IMPROVEMENTS			1989	40,935		31.5	1,299	1,299	27,870	12
13	DRIVEWAY			1989	17,137		15			17,137	13
14	IMPROVEMENTS			1990	37,367		31.5	1,186	1,186	24,262	14
15	IMPROVEMENTS			1991	45,002		31.5	1,428	1,428	27,607	15
16	IMPROVEMENTS			1992	49,649		31.5	1,577	1,577	29,081	16
17	ROOF TOP A/C UNITS			1993	9,100		31.5	289	289	5,178	17
18	IMPROVEMENTS			1993	53,243		39	1,366	1,366	23,755	18
19	IMPROVEMENTS			1994	31,230		39	801	801	13,333	19
20	FLOOR COVERING			1995	795		15			795	20
21	HAND RAIL			1995	2,249		39	58	58	921	21
22	FLOOR TILES			1995	5,471		39	140	140	2,188	22
23	WINDOW A/C UNITS			1995	14,146		39	363	363	5,610	23
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056		39	309	309	4,803	24
25	ALARM			1995	1,337		39	34	34	526	25
26	LAUNDRY BUILDING			1995	35,000		39	897	897	13,717	26
27	ROOF			1995	5,520		39	142	142	2,171	27
28	WINDOWS			1995	9,478		39	243	243	3,696	28
29	DOOR EDGE & DOOR FRAME			1996	2,099		39	54	54	808	29
30	LAUNDRY BUILDING			1996	175,187		39	4,491	4,491	65,317	30
31	AIR COOLERS			1996	6,642		39	171	171	2,477	31
32	RACING CAGE			1996	3,987		39	102	102	1,483	32
33	HAND RAIL			1996	1,156		39	30	30	431	33
34	WINDOWS			1996	11,496		39	295	295	4,241	34
35	TACK ROOM			1996	2,139		39	55	55	786	35
36	NEW CONFERENCE ROOM TILE			1997	2,938		39	76		1,010	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	INSTALL DIETARY DOOR	1997	$ 1,478	$	39	$ 38	$ 38	$ 505	37
38	NURSING STATION - 2ND FLOOR	1997	5,397		39	138	138	1,812	38
39	WINDON-NURSING OFFICE	1997	1,382		39	35	35	459	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107		39	28	28	391	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927		39	126	126	1,602	41
42	THE PARKING LOT	1998	42,711		15	2,990	2,990	35,688	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223		39	160	160	2,063	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715		39	326	326	3,953	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473		39	269	269	3,217	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452		39	89	89	1,042	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495		39	38	38	445	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877		39	74	74	860	48
49	REMODELING F WING SHOWER ROOM	1999	8,988		39	230	230	2,655	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370		39	61	61	699	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760		39	71	71	796	51
52	WATER HEATER - DIETARY	1999	2,931		39	75	75	834	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073		39	79	79	879	53
54	TILE - DINING ROOM	1999	1,212		39	31	31	345	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200		39	185	185	2,058	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738		39	70	70	773	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265		20	163	163	1,793	57
58	WATER HEATER - DIETARY	2000	3,573		27.5	130	130	1,338	58
59	GENERAL CONSTRUCTION	2000	27,448		27.5	998	998	10,188	59
60	ROOF REPAIR	2000	4,200		27.5	153	153	1,562	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910		27.5	106	106	1,064	61
62	NEW A/C UNIT ROOF TOP	2000	4,694		27.5	171	171	1,717	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523		20	4,026	4,026	44,286	63
64	SHOWER ROOM RENOVATIONS	2001	30,586		27.5	1,112	1,112	10,889	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341		27.5	3,903	3,903	36,591	65
66	WATER HEATER - LAUNDRY	2001	9,108		27.5	331	331	2,993	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464		27.5	453	453	4,096	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861		20	13,543	13,543	135,430	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114		20	1,456	1,456	13,104	69
70	TOTAL (lines 4 thru 69)		$ 6,386,654	$ 129,074		$ 177,554	$ 176,155	$ 2,727,494	70

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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		$ 6,386,654	$ 129,074		$ 177,554	$ 48,480	$ 2,727,494	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997		15	600	600	4,980	2
3	SHOWER ROOM	2002	30,924		27.5	1,125	1,125	9,234	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010		27.5	328	328	2,638	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891		27.5	541	541	4,351	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056		20	2,003	2,003	18,027	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499		20	575	575	5,175	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767		27.5	464	464	3,461	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152		27.5	1,133	1,133	8,450	9
10	THERAPY ROOM -FLOORING	2003	87,509		27.5	3,182	3,182	23,732	10
11	CONFERENCE ROOM-FLOORING	2003	2,073		27.5	76	76	567	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421		27.5	270	270	1,744	12
13	TONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825		27.5	3,266	3,266	20,549	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925		27.5	1,852	1,852	11,498	14
15	RESIDENT ROOMS-FLOORING	2005	9,821		27.5	357	357	2,038	15
16	INSTALL CABLING SYSTEM	2005	46,771		27.5	1,701	1,701	9,568	16
17	INSTALL TWO AUTOMATIC SLIDING DOOR	2005	28,000		27.5	1,018	1,018	5,132	17
18	1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE	2005	58,286		20	2,914	2,914	17,484	18
19	INSTALL DOORS - F WING, RESIDENT ROOMS	2006	4,260		27.5	155	155	756	19
20	WALLCOVERING, FLOORING - 1ST FLOOR CORRID	2006	63,838		27.5	2,321	2,321	11,121	20
21	AIR CONDITIONS	2006	7,968		27.5	289	289	1,296	21
22	REPLACEMENT WALK - IN FREEZER DOOR	2006	4,652		27.5	169	169	768	22
23	REPLACEMENT OF KITCHEN TILES	2007	13,200		27.5	380	380	1,520	23
24									24
25	WESTMONT REAL ESTATE, LLC								25
26	NEW PARKING LOT	2007	206,876	13,792	15	13,792		44,874	26
27	RESIDENT ROOMS-FLOORING, WINGS B,C,D,E,F	2007	235,801	8,575	27.5	8,575		29,655	27
28	RESIDENT ROOMS-PAINTING, WINGS B,C,D,E,F	2007	84,360	9,718	5	9,718		69,783	28
29	INSTALL NEW FIRE DOORS IN EXIST. FRAME E WING	2007	3,108	113	27.5	113		391	29
30	TUCKPOINTING, AIR CONDITIONS, WATER HEATER	2007	18,594	2,142	5	2,142		15,381	30
31	INSTALLATION OF RAILLING ON EXTERIROR STAIRS	2007	6,407	233	27.5	233		805	31
32	REPLACE EXISTING RECEIVING DR/FRAME/HARDWARE	2007	3,108	113	27.5	113		391	32
33	AIR CONDITIONS	2008	12,661	1,215	5	1,215		10,838	33
34	TOTAL (lines 1 thru 33)		$ 7,591,414	$ 164,975		$ 238,174	$ 73,199	$ 3,063,701	34

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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		$ 7,591,414	$ 164,975		$ 238,174	$ 73,199	$ 3,063,701	1
2	FLAT WORK OF CONCRETE	2008	3,640	132	27.5	132		324	2
3	DINING ROOM - INSTALLATION OF DOOR	2008	2,869	105	27.5	105		258	3
4	A WING DOUDLE EGRESS FIRE	2008	2,948	107	27.5	107		264	4
5	2ND FLOOR CORRIDOR-CARPET, WALLCOVERING	2009	103,122	32,999	5	32,999		53,623	5
6	WALL AIR CONDITIONS	2009	9,397	1,503	5	1,503		7,142	6
7	1ST FLOOR RESIDENT ROOMS-WINDOW TREATMENTS	2009	16,265	5,205	5	5,205		8,458	7
8	INSTALLATION OF SIGNAGE	2009	8,020	535	15	535		669	8
9	EMPLOYEES BREAKROOM-PAINTING, LIGHTING	2009	2,371	86	27.5	86		154	9
10	INSTALLATION OF CAT CABLES SYSTEM	2009	3,825	139	27.5	139		249	10
11	INSTALL PANIC BARS ON DINING ROOM ENTRY DOORS	2009	5,362	195	27.5	195		350	11
12	WALL AIR CONDITIONS	2010	7,612	5,135	5	5,135		5,135	12
13	1ST FLOOR DINING ROOM-WALLCOVERING, BLINDS	2010	19,660	3,932	5	3,932		3,932	13
14	A-WING RESIDENT ROOM-BUIT-IN WARDROBES	2010	11,222	102	27.5	102		102	14
15	INSTALLED NEW FUEL TANK & PIPING TO ENGINE LINES	2010	6,374	58	27.5	58		58	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)		$ 7,794,101	$ 215,208		$ 288,407	$ 73,199	$ 3,144,419	34

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 404,550	$	$ 41,515	$ 41,515	3-10	$ 301,589	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	692,455					692,455	73
74	RELATED PARTY SL DEPRECIATION		106,274	106,274				74
75	TOTALS	$ 1,097,005	$ 106,274	$ 147,789	$ 41,515		$ 994,044	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,650,932	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 321,482	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 436,196	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 114,714	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,138,463	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 WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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: $ 52,797 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	FACILITY	2007 FORD WAGON	$ 775.00	$ 9,300	17
18					18
19					19
20					20
21	TOTAL		$ 775.00	$ 9,300	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 AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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 WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 344,942	$		$ 344,942	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			145,306			145,306	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			478,703			478,703	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				304,469		304,469	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	RADIOLOGY, LABORATORY Other (specify): MEDICAL SUPPLIES	39-2 39-2					17,336 19,138		17,336 19,138	13
14	TOTAL			$		$ 968,951	$ 340,943		$ 1,309,894	14

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 686,090	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,263,058		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	131,088		6
7	Other Prepaid Expenses	55,914		7
8	Accounts Receivable (owners or related parties)	159,042		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,295,192	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **GOODWILL**	7,500,000		22
23	Other(specify): **AMORT OF GOODWILL**	(1,166,667)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,333,333	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,628,525	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 130,760	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	216,088		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,882		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)**	$ 371,730	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,123,447		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,123,447	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,495,177	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,133,348	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,628,525	$	48

***(See instructions.)**

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 787,816	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 787,818	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	945,530	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	(600,000)	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)**	$ 345,530	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)**	$ 1,133,348	24 *

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 12,877,102	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,877,102	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	486,333	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 486,333	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	8,211	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,000	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)**	$ 10,211	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,953	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,953	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COMPUTER INCOME	63,250	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 63,250	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,453,849	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,863,041	31
32	Health Care	4,255,629	32
33	General Administration	2,983,146	33
	B. Capital Expense		
34	Ownership	1,967,959	34
	C. Ancillary Expense		
35	Special Cost Centers	1,309,894	35
36	Provider Participation Fee	117,713	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,497,382	40
41	**Income before Income Taxes (line 30 minus line 40)****	956,467	41
42	**Income Taxes**	(10,937)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 945,530	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	1,888	1,944	$ 70,233	$ 36.13	1
2	Assistant Director of Nursing	1,687	1,695	47,287	27.90	2
3	Registered Nurses	29,957	31,414	920,369	29.30	3
4	Licensed Practical Nurses	27,855	28,588	719,476	25.17	4
5	CNAs & Orderlies	123,530	127,409	1,343,485	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,736	13,807	212,116	15.36	8
9	Activity Director	2,416	2,480	38,553	15.55	9
10	Activity Assistants	11,597	12,066	107,164	8.88	10
11	Social Service Workers	6,520	6,960	130,598	18.76	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,080	36,398	17.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,578	29,454	273,876	9.30	15
16	Dishwashers					16
17	Maintenance Workers	7,357	7,841	108,171	13.80	17
18	Housekeepers	49,657	51,973	461,364	8.88	18
19	Laundry	8,449	9,015	74,105	8.22	19
20	Administrator	2,080	2,080	125,969	60.56	20
21	Assistant Administrator	1,960	2,120	78,381	36.97	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,074	21,360	359,142	16.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,104	2,240	39,873	17.80	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,726	6,118	81,097	13.26	31
32	Other Health C: MDS	5,235	5,859	176,199	30.07	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	350,334	366,503	$ 5,403,856 *	$ 14.74	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		$ 0	1-3	35
36	Medical Director	Monthly	58,000	9-3	36
37	Medical Records Consultant	20	1,140	10-3	37
38	Nurse Consultant	Monthly	33,328	10-3	38
39	Pharmacist Consultant	875	3,498	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	20	1,169	11-3	44
45	Social Service Consultant	66	3,806	12-3	45
46	Other(specify) Physicians	Monthly	5,263	10-3	46
47	Utilization Review Fees	Monthly	1,200	10-3	47
48				10-3	48
49	TOTAL (lines 35 - 48)	981	$ 107,404		49

C. CONTRACT NURSES

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KAY P ROSS	ADMINISTRATOR	0	$ 125,969
HELEN SICAT	ASST ADMIN	0	78,381
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 204,350

B. Administrative - Other

Description		Amount
DA WESTMONT	MANAGEMENT FEES	$ 957,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 957,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		88,260
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 88,260

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 128,371
Unemployment Compensation Insurance	52,156
FICA Taxes	404,574
Employee Health Insurance	100,005
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	112,725
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	8,241
INSURANCE - EXECUTIVE LIFE VI 21	(8,241)
TOTAL (agree to Schedule V, line 22, col.8)	$ 797,831

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	$ 1,990
Advertising: Employee Recruitment	21,961
Health Care Worker Background Check	2,500
(Indicate # of checks performed 63)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	18,529
MARKETING/ADV/PROMO	38,072
LICENSES/DUES/SUBSCRIPTIONS	14,477
MGMT CO ALLOC	75
TRUST/FRANCHISE/CONTRIB/ETC	(18,529)
Less: Public Relations Expense	(0)
Non-allowable advertising	(38,072)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,003

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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			$		$	$	$	$	$	$	$	$	$
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 AND REHAB CENTER # 0050120 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 $9,638**

(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. $ **43,750** Line **10-2**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
WESTMONT CONVALESCENT CENTER, # 0030015 09/03/08

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **117,713**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.