FOR BHF USE

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0050120

Facility Name: WESTMONT NURSING AND REHAB CENTER, LLC

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		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: 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 01/01/2011 to 12/31/2011 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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	9,683	2,114	10,344	22,141	8
9	SNF/PED					9
10	ICF	42,528	7,623	47	50,198	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,211	9,737	10,391	72,339	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.18%

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 8,715

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: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CEN # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	319,198	35,957	12,006	367,161		367,161		367,161			1
2	Food Purchase		398,932		398,932		398,932	(1,640)	397,292			2
3	Housekeeping	461,450	81,758		543,208		543,208		543,208			3
4	Laundry	77,323	33,914	4,848	116,085		116,085		116,085			4
5	Heat and Other Utilities			279,736	279,736		279,736	407	280,143			5
6	Maintenance	100,870	58,786	24,321	183,977		183,977	1,041	185,018			6
7	Other (specify):*			10,261	10,261		10,261		10,261			7
8	**TOTAL General Services**	958,841	609,347	331,172	1,899,360		1,899,360	(192)	1,899,168			8
	B. Health Care and Programs											
9	Medical Director			62,500	62,500		62,500		62,500			9
10	Nursing and Medical Records	3,600,313	280,921	109,077	3,990,311		3,990,311		3,990,311			10
10a	Therapy	244,395	7,250		251,645		251,645		251,645			10a
11	Activities	179,844	1,707	988	182,539		182,539		182,539			11
12	Social Services	123,167		1,416	124,583		124,583		124,583			12
13	CNA Training											13
14	Program Transportation			265	265		265		265			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,147,719	289,878	174,246	4,611,843		4,611,843		4,611,843			16
	C. General Administration											
17	Administrative	191,110		894,000	1,085,110		1,085,110	(541,498)	543,612			17
18	Directors Fees											18
19	Professional Services			146,891	146,891		146,891	(11,911)	134,980			19
20	Dues, Fees, Subscriptions & Promotions			78,139	78,139		78,139	(42,714)	35,425			20
21	Clerical & General Office Expenses	363,092	49,658	65,616	478,366		478,366	(121,246)	357,120			21
22	Employee Benefits & Payroll Taxes			913,501	913,501		913,501	(8,241)	905,260			22
23	Inservice Training & Education			1,299	1,299		1,299		1,299			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			18,077	18,077		18,077		18,077			25
26	Insurance-Prop.Liab.Malpractice			236,845	236,845		236,845	100	236,945			26
27	Other (specify):*			123,102	123,102		123,102	(123,102)				27
28	**TOTAL General Administration**	554,202	49,658	2,477,470	3,081,330		3,081,330	(848,612)	2,232,718			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,660,762	948,883	2,982,888	9,592,533		9,592,533	(848,804)	8,743,729			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, L #0050120 **Report Period Beginning: 01/01/2011** **Ending: 12/31/2011**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,000	
	REPAIRS & MAINTENANCE		3,006	
			0	12,006
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,848	
			0	4,848
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		41,026	
	ELECTRICITY		104,881	
	WATER		115,873	
	CABLE TV - LOBBY		17,956	
			0	279,736
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,425	
	PAINTING & DECORATING		2,297	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		6,346	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,575	
	FIRE SERVICE		3,678	
			0	
			0	
			0	
			0	24,321
7	**OTHER**			
	SCAVENGER		10,261	
	SECURITY SERVICE		0	
			0	
			0	10,261
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	62,500	62,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		36,325	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,500	
	PHARMACY CONSULTANT	XVIII B 39-2	3,521	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	4,797	
	PSYCHIATRIC	XVIII B __-2	212	
	RN CONSULTANT	XVIII B 38-2	62,722	
			0	
			0	109,077
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		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	988	
			0	988
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,416	
				1,416
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, LLC #0050120 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		265	265
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	894,000	894,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	61,835	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	85,056	
			0	146,891
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	34,089	
	EMPLOYEE WANT ADS	XIX F	13,295	
	CONTRIBUTIONS	VI 20 XIX F	2,700	
	DUES & SUBSCRIPTIONS	XIX F	18,382	
	LICENSES & PERMITS	XIX F	1,966	
	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	5,967	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,640	
	PATIENT BACKGROUND CHECKS	XIX F	100	
				78,139
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		54	
	EQUIPMENT REPAIR & MAINTENANCE		22,219	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	7,020	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		36,323	
	MESSENGER SERVICE		0	
			0	65,616

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	427,518	
	UNEMPLOYMENT COMPENSATION	XIX D	89,093	
	WORKERS COMPENSATION INSURANC	XIX D	164,767	
	HOSPITALIZATION INSURANCE	XIX D	102,320	
	EMPLOYEE BENEFITS - OTHER	XIX D	121,562	
	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	913,501
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,299	
				1,299
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,077	
				18,077
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		236,845	
				236,845
27	**OTHER**			
	BAD DEBTS	VI 24	123,102	
				123,102

GRAND TOTAL COLUMN 3 OTHER **2,982,888**

WESTMONT NURSING AND REHAB CENTER, LLC
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	398,932
LESS SALES TAX	(1,640)
NET FOOD	397,292
TOTAL PATIENT CENSUS	72,339
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	217,017
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	217,017
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	217,017
NET FOOD	397,292
DIVIDE TOTAL MEALS/YEAR	217,017
COST PER MEAL	1.83
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, LLC #0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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							392,762	392,762			30
31	Amortization of Pre-Op. & Org.			500,000	500,000		500,000	(500,000)				31
32	Interest			414,570	414,570		414,570	232,725	647,295			32
33	Real Estate Taxes							125,157	125,157			33
34	Rent-Facility & Grounds			954,600	954,600		954,600	(954,600)				34
35	Rent-Equipment & Vehicles			94,196	94,196		94,196	666	94,862			35
36	Other (specify):* OFFICE RENT			15,435	15,435		15,435	36,575	52,010			36
37	TOTAL Ownership			1,978,801	1,978,801		1,978,801	(666,715)	1,312,086			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		283,266	1,102,250	1,385,516		1,385,516		1,385,516			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		283,266	1,219,963	1,503,229		1,503,229		1,503,229			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,660,762	1,232,149	6,181,652	13,074,563		13,074,563	(1,515,519)	11,559,044			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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	99,107	30		9
10	Interest and Other Investment Income	(998)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,640)	2		13
14	Non-Care Related Interest	(400,524)	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	(7,020)	21		18
19	Entertainment		20		19
20	Contributions	(8,667)	20		20
21	Owner or Key-Man Insurance	(8,241)	22		21
22	Special Legal Fees & Legal Retainers	(13,947)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(123,102)	27		24
25	Fund Raising, Advertising and Promotional	(34,089)	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	(614,226)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,113,347)		$	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)	(402,172)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (402,172)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,515,519)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WESTMONT NURSING AND REHAB CENTER, LLC

ID# 0050120

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ -114,226	21	1
2	AMORTIZATION OF GOODWILL	(500,000)	31	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**	(614,226)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(1,640)	0	0	0	0	0	0	0	0	0	0	(1,640)	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	407	0	0	0	0	0	0	0	0	407	5
6	Maintenance	0	0	1,041	0	0	0	0	0	0	0	0	1,041	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,640)	0	1,448	0	0	0	0	0	0	0	0	(192)	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	(541,498)	0	0	0	0	0	0	0	0	(541,498)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,947)	0	2,036	0	0	0	0	0	0	0	0	(11,911)	19
20	Fees, Subscriptions & Promotions	(42,756)	0	42	0	0	0	0	0	0	0	0	(42,714)	20
21	Clerical & General Office Expenses	(121,246)	0	0	0	0	0	0	0	0	0	0	(121,246)	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	100	0	0	0	0	0	0	0	0	100	26
27	Other (specify):*	(123,102)	0	0	0	0	0	0	0	0	0	0	(123,102)	27
28	TOTAL General Administration	(309,292)	0	(539,320)	0	0	0	0	0	0	0	0	(848,612)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(310,932)	0	(537,872)	0	0	0	0	0	0	0	0	(848,804)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, LLC # 0050120 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	99,107	292,320	1,335	0	0	0	0	0	0	0	0	392,762	30
31	Amortization of Pre-Op. & Org.	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	31
32	Interest	(401,522)	631,985	2,262	0	0	0	0	0	0	0	0	232,725	32
33	Real Estate Taxes	0	122,969	2,188	0	0	0	0	0	0	0	0	125,157	33
34	Rent-Facility & Grounds	0	(954,600)	0	0	0	0	0	0	0	0	0	(954,600)	34
35	Rent-Equipment & Vehicles	0	0	666	0	0	0	0	0	0	0	0	666	35
36	Other (specify):*	0	52,010	(15,435)	0	0	0	0	0	0	0	0	36,575	36
37	**TOTAL Ownership**	(802,415)	144,684	(8,984)	0	0	0	0	0	0	0	0	(666,715)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,113,347)	144,684	(546,856)	0	0	0	0	0	0	0	0	(1,515,519)	45

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

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	$ 954,600	WESTMONT REAL ESTATE, LLC	100.00%	$	$ (954,600)	1
2	V	30	DEPRECIATION (SL)		" " "		292,320	292,320	2
3	V	32	INTEREST		" " "		622,039	622,039	3
4	V	32	AMORT LOAN COST		" " "		9,946	9,946	4
5	V	33	REAL ESTATE TAXES		" " "		122,969	122,969	5
6	V	36	MIP INSURANCE		" " "		52,010	52,010	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 954,600			$ 1,099,284	$ * 144,684	14

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 15,435	IME REALTY CORP		$	$ (15,435)	15
16	V	5	UTILITIES		" " "		407	407	16
17	V	6	REPAIRS/MAINT		" " "		1,041	1,041	17
18	V	19	ACCOUNTING FEES		" " "		76	76	18
19	V	20	LICENSES & PERMITS		" " "		42	42	19
20	V	26	INSURANCE		" " "		100	100	20
21	V	30	DEPRECIATION (SL)		" " "		1,335	1,335	21
22	V	32	INTEREST		" " "		2,262	2,262	22
23	V	33	RE TAX		" " "		2,188	2,188	23
24	V	35	STORAGE FEES		" " "		666	666	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V	17	MANAGEMENT FEES	894,000	DA WESTMONT			(894,000)	30
31	V	19	ACCOUNTING FEES		" " "		1,960	1,960	31
32	V	17	ADMIN CONSULTANT-S.HOLT		" " "		88,705	88,705	32
33	V	17	ADMIN CONSULTANT-A.R.M.		" " "		263,797	263,797	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 909,435			$ 362,579	$ * (546,856)	39

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CEI # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	ALLOCATION FROM DA WESTMONT:				SEE				$		1
2	FLORA WEISS (A.R.M. ENTERPRISES)	ADMIN CONSULTANT		0.00	ATTACHED SCHEDULES			CONSULT FEE	263,797	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 263,797		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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	195,459	14	$ 5,131	$	15,435	$ 407	1
2	6	REPAIRS/MAINT	INCOME	195,459	14	13,157		15,435	1,041	2
3	19	ACCOUNTING FEES	INCOME	195,459	14	973		15,435	76	3
4	20	LICENSES & PERMITS	INCOME	195,459	14	526		15,435	42	4
5	26	INSURANCE	INCOME	195,459	14	1,254		15,435	100	5
6	30	DEPRECIATION (SL)	INCOME	195,459	14	16,930		15,435	1,335	6
7	32	INTEREST	INCOME	195,459	14	28,650		15,435	2,262	7
8	33	RE TAX	INCOME	195,459	14	27,693		15,435	2,188	8
9	35	STORAGE FEES	INCOME	195,459	14	8,451		15,435	666	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 102,765	$		$ 8,117	25

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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: DA WESTMONT
Street Address: 6865 N LINCOLN
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	19	ACCOUNTING FEES	CENSUS DAYS	91,323	3	$ 2,475	$	72,339	$ 1,960	1
2	17	ADMIN CONSULTANT-S.HOLT	CENSUS DAYS	91,323	3	111,983		72,339	88,705	2
3	17	ADMIN CONSULTANT-A.R.M.	CENSUS DAYS	91,323	3	333,025		72,339	263,797	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 447,483	$		$ 354,462	25

Facility Name & ID Number WESTMONT NURSING AND REHAB CEN # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		11/17/06	10,881,400	10,346,337	12/01/41	5.9800	622,039	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN			348,110	297,081			9,946	3
4												4
5	RELATED PARTY											5
	Working Capital											
6	MB FINANCIAL	X		WORKING CAPITAL	DEMAND	9/5/08	2,000,000	1,505,000		4.5000	10,219	6
7	F & M WEISS	X		WORKING CAPITAL	$11,602.93	11/1/11	393,000	362,018	10/1/14	4.0000	3,827	7
8	IME REALTY ALLOCATION											8
9	TOTAL Facility Related				$11,602.93		$ 13,622,510	$ 12,510,436			$ 646,031	9
	B. Non-Facility Related*											
10	BRICKYRD BANK		X	GOODWILL	$29,590.38	09/08	1,500,000			6.7500	28,499	10
11	GOODWILL		X	GOODWILL	$42,088.99	09/08	7,500,000	6,127,688	09/33	6.0000	372,025	11
12												12
13												13
14	TOTAL Non-Facility Related				$71,679.37		$ 9,000,000	$ 6,127,688			$ 400,524	14
15	TOTALS (line 9+line14)						$ 22,622,510	$ 18,638,124			$ 1,046,555	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 116,020	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.)		$ 118,900	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,880	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 120,089	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.		$ 122,969	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	101,943	8
	2007	103,511	9
	2008	111,229	10
	2009	114,871	11
	2010	118,900	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 2010 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTMONT NURSING AND REHAB CENTER, LLC 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-22-101-001	NURSING HOME	$ 106,199.44	$ 106,199.44
2.	09-22-101-002	NURSING HOME	$ 5,267.18	$ 5,267.18
3.	09-22-101-003	NURSING HOME	$ 7,432.96	$ 7,432.96
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 118,899.58	$ 118,899.58

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 2,145,276	4
5											5
6											6
7											7
8	IME REALTY ALLOCATIONS					1,284		1,284			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	33,271	11
12	IMPROVEMENTS			1989	40,935		31.5	1,299	1,299	29,169	12
13	DRIVEWAY			1989	17,137		15			17,137	13
14	IMPROVEMENTS			1990	37,367		31.5	1,186	1,186	25,448	14
15	IMPROVEMENTS			1991	45,002		31.5	1,428	1,428	29,035	15
16	IMPROVEMENTS			1992	49,649		31.5	1,577	1,577	30,658	16
17	ROOF TOP A/C UNITS			1993	9,100		31.5	289	289	5,467	17
18	IMPROVEMENTS			1993	53,243		39	1,366	1,366	25,121	18
19	IMPROVEMENTS			1994	31,230		39	801	801	14,134	19
20	FLOOR COVERING			1995	795		15			795	20
21	HAND RAIL			1995	2,249		39	58	58	979	21
22	FLOOR TILES			1995	5,471		39	140	140	2,328	22
23	WINDOW A/C UNITS			1995	14,146		39	363	363	5,973	23
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056		39	309	309	5,112	24
25	ALARM			1995	1,337		39	34	34	560	25
26	LAUNDRY BUILDING			1995	35,000		39	897	897	14,614	26
27	ROOF			1995	5,520		39	142	142	2,313	27
28	WINDOWS			1995	9,478		39	243	243	3,939	28
29	DOOR EDGE & DOOR FRAME			1996	2,099		39	54	54	862	29
30	LAUNDRY BUILDING			1996	175,187		39	4,491	4,491	69,808	30
31	AIR COOLERS			1996	6,642		39	171	171	2,648	31
32	RACING CAGE			1996	3,987		39	102	102	1,585	32
33	HAND RAIL			1996	1,156		39	30	30	461	33
34	WINDOWS			1996	11,496		39	295	295	4,536	34
35	TACK ROOM			1996	2,139		39	55	55	841	35
36	NEW CONFERENCE ROOM TILE			1997	2,938		39	76	76	1,086	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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL DIETARY DOOR	1997	$ 1,478	$	39	$ 38	$ 38	$ 543	37
38	NURSING STATION - 2ND FLOOR	1997	5,397		39	138	138	1,950	38
39	WINDON-NURSING OFFICE	1997	1,382		39	35	35	494	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107		39	28	28	419	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1998	4,927		39	126	126	1,728	41
42	THE PARKING LOT	1998	42,711		15	2,990	2,990	38,678	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL TI	1998	6,223		39	160	160	2,223	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715		39	326	326	4,279	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473		39	269	269	3,486	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452		39	89	89	1,131	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495		39	38	38	483	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877		39	74	74	934	48
49	REMODELING F WING SHOWER ROOM	1999	8,988		39	230	230	2,885	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370		39	61	61	760	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760		39	71	71	867	51
52	WATER HEATER - DIETARY	1999	2,931		39	75	75	909	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073		39	79	79	958	53
54	TILE - DINING ROOM	1999	1,212		39	31	31	376	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200		39	185	185	2,243	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738		39	70	70	843	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265		20	163	163	1,956	57
58	WATER HEATER - DIETARY	2000	3,573		27.5	130	130	1,468	58
59	GENERAL CONSTRUCTION	2000	27,448		27.5	998	998	11,186	59
60	ROOF REPAIR	2000	4,200		27.5	153	153	1,715	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910		27.5	106	106	1,170	61
62	NEW A/C UNIT ROOF TOP	2000	4,694		27.5	171	171	1,888	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523		20	4,026	4,026	48,312	63
64	SHOWER ROOM RENOVATIONS	2001	30,586		27.5	1,112	1,112	12,001	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341		27.5	3,903	3,903	40,494	65
66	WATER HEATER - LAUNDRY	2001	9,108		27.5	331	331	3,324	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464		27.5	453	453	4,549	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861		20	13,543	13,543	148,973	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114		20	1,456	1,456	14,560	69
70	TOTAL (lines 4 thru 69)		$ 6,386,654	$ 129,035		$ 177,515	$ 48,480	$ 2,903,725	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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,386,654	$ 129,035		$ 177,515	$ 48,480	$ 2,903,725	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997		15	600	600	5,580	2
3	SHOWER ROOM	2002	30,924		27.5	1,125	1,125	10,359	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010		27.5	328	328	2,966	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891		27.5	541	541	4,892	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056		20	2,003	2,003	20,030	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499		20	575	575	5,750	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767		27.5	464	464	3,925	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152		27.5	1,133	1,133	9,583	9
10	THERAPY ROOM -FLOORING	2003	87,509		27.5	3,182	3,182	26,914	10
11	CONFERENCE ROOM-FLOORING	2003	2,073		27.5	76	76	643	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421		27.5	270	270	2,014	12
13	TONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825		27.5	3,266	3,266	23,815	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925		27.5	1,852	1,852	13,350	14
15	RESIDENT ROOMS-FLOORING	2005	9,821		27.5	357	357	2,395	15
16	INSTALL CABLING SYSTEM	2005	46,771		27.5	1,701	1,701	11,269	16
17	INSTALL TWO AUTOMATIC SLIDING DOOR	2005	28,000		27.5	1,018	1,018	6,150	17
18	1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE	2005	58,286		20	2,914	2,914	20,398	18
19	INSTALL DOORS - F WING, RESIDENT ROOMS	2006	4,260		27.5	155	155	911	19
20	WALLCOVERING, FLOORING - 1ST FLOOR CORRID	2006	63,838		27.5	2,321	2,321	13,442	20
21	AIR CONDITIONS	2006	7,968		27.5	289	289	1,585	21
22	REPLACEMENT WALK - IN FREEZER DOOR	2006	4,652		27.5	169	169	937	22
23	REPLACEMENT OF KITCHEN TILES	2007	13,200		27.5	380	380	1,900	23
24									24
25	WESTMONT REAL ESTATE, LLC								25
26	NEW PARKING LOT	2007	206,876	13,792	15	13,792		58,666	26
27	RESIDENT ROOMS-FLOORING, WINGS B,C,D,E,F	2007	235,801	8,575	27.5	8,575		38,230	27
28	RESIDENT ROOMS-PAINTING, WINGS B,C,D,E,F	2007	84,360	9,718	5	9,718		79,501	28
29	INSTALL NEW FIRE DOORS IN EXIST. FRAME E WING	2007	3,108	113	27.5	113		504	29
30	TUCKPOINTING, AIR CONDITIONS, WATER HEATER	2007	18,594	2,142	5	2,142		17,523	30
31	INSTALLATION OF RAILLING ON EXTERIROR STAIRS	2007	6,407	233	27.5	233		1,038	31
32	REPLACE EXISTING RECEIVING DR/FRAME/HARDWARE	2007	3,108	113	27.5	113		504	32
33	AIR CONDITIONS	2008	12,661	729	5	729		11,567	33
34	TOTAL (lines 1 thru 33)		$ 7,591,414	$ 164,450		$ 237,649	$ 73,199	$ 3,300,066	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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,591,414	$ 164,450		$ 237,649	$ 73,199	$ 3,300,066	1
2	FLAT WORK OF CONCRETE	2008	3,640	132	27.5	132		456	2
3	DINING ROOM - INSTALLATION OF DOOR	2008	2,869	105	27.5	105		363	3
4	A WING DOUDLE EGRESS FIRE	2008	2,948	107	27.5	107		371	4
5	2ND FLOOR CORRIDOR-CARPET, WALLCOVERING	2009	103,122	19,799	5	19,799		73,422	5
6	WALL AIR CONDITIONS	2009	9,397	902	5	902		8,044	6
7	1ST FLOOR RESIDENT ROOMS-WINDOW TREATMENTS	2009	16,265	3,123	5	3,123		11,581	7
8	INSTALLATION OF SIGNAGE	2009	8,020	535	15	535		1,204	8
9	EMPLOYEES BREAKROOM-PAINTING, LIGHTING	2009	2,371	86	27.5	86		240	9
10	INSTALLATION OF CAT CABLES SYSTEM	2009	3,825	139	27.5	139		388	10
11	INSTALL PANIC BARS ON DINING ROOM ENTRY DOORS	2009	5,362	195	27.5	195		545	11
12	WALL AIR CONDITIONS	2010	7,612	991	5	991		6,126	12
13	1ST FLOOR DINING ROOM-WALLCOVERING, BLINDS	2010	19,660	6,291	5	6,291		10,223	13
14	A-WING RESIDENT ROOM-BUIT-IN WARDROBES	2010	11,222	408	27.5	408		510	14
15	INSTALLED NEW FUEL TANK & PIPING TO ENGINE LINES	2010	6,374	232	27.5	232		290	15
16	1ST FLOOR DINING ROOM.MEDICAL RECORDS,2ND FLOOR								16
17	DINING ROOM,ACTIVITY ROOM,BEAUTY SHOP, UTILITY								17
18	ROOM-FLOORING. WINDOW TREATMENTS	2011	19,818	3,964	5	3,964		3,964	18
19	INSTALL WATER HEATER	2011	11,585	333	27.5	333		333	19
20	INSTALL FOUR DELAYED EGRESS LOCKS FOR 2ND FLOOR	2011	6,150	159	27.5	159		159	20
21	INSTALL FIRE ALARM SMOKES, HEATS, AV DEVCIE	2011	85,377	1,941	27.5	1,941		1,941	21
22	1ST & 2ND FLOOR DINING ROOMS-CHAIR RAIL	2011	14,720	245	27.5	245		245	22
23	INSTALL NEW EXHAUST VENT	2011	2,508	34	27.5	34		34	23
24	INSTALL NEW CONTROLLER & ANNUNCIATER	2011	9,245	14	27.5	14		14	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)		$ 7,943,504	$ 204,185		$ 277,384	$ 73,199	$ 3,420,519	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, L # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 269,097	$	$ 25,908	$ 25,908	3-10	$ 192,044	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	827,908					827,908	73
74	RELATED PARTY SL DEPRECIATION		89,470	89,470				74
75	TOTALS	$ 1,097,005	$ 89,470	$ 115,378	$ 25,908		$ 1,019,952	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,800,335	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 293,655	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 392,762	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 99,107	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,440,471	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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.		$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 78,859 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	$ 2,325	17
18	FACILITY	2011 FORD SHUTTLE BUS	#######	13,012	18
19					19
20					20
21	TOTAL		$ #######	$ 15,337	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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	39-3	hrs	$		$ 392,280	$		$ 392,280	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			159,706			159,706	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			550,264			550,264	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				247,743		247,743	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	RADIOLOGY, LABORATORY Other (specify): MEDICAL SUPPLIES	39-2 39-2					16,570 18,953		16,570 18,953	13
14	TOTAL			$		$ 1,102,250	$ 283,266		$ 1,385,516	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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 122,980	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,438,339		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	140,581		6
7	Other Prepaid Expenses	8,358		7
8	Accounts Receivable (owners or related parties)	433,762		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,144,020	$	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	(1,666,667)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,833,333	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,977,353	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 294,411	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,505,000		29
30	Accrued Salaries Payable	231,018		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,116		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)**	$ 2,069,545	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,489,706		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)**	$ 6,489,706	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,559,251	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,418,102	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,977,353	$	48

***(See instructions.)**

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,133,348	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,133,353	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	944,749	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	(660,000)	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)**	$ 284,749	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)**	$ 1,418,102	24 *

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 13,306,840	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,306,840	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	636,175	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 636,175	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,750	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,750	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	998	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 998	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COMPUTER INCOME	74,500	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 74,500	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,020,263	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,899,360	31
32	Health Care	4,611,843	32
33	General Administration	3,081,330	33
	B. Capital Expense		
34	Ownership	1,978,801	34
	C. Ancillary Expense		
35	Special Cost Centers	1,385,516	35
36	Provider Participation Fee	117,713	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,074,563	40
41	**Income before Income Taxes (line 30 minus line 40)****	945,700	41
42	**Income Taxes**	(951)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 944,749	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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2,192	2,364	$ 108,468	$ 45.88	1
2	Assistant Director of Nursing	1,912	1,920	66,493	34.63	2
3	Registered Nurses	28,809	30,185	893,959	29.62	3
4	Licensed Practical Nurses	29,069	29,901	752,725	25.17	4
5	CNAs & Orderlies	128,438	132,939	1,405,826	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,925	14,961	244,395	16.34	8
9	Activity Director	3,064	3,200	52,158	16.30	9
10	Activity Assistants	12,995	13,886	127,686	9.20	10
11	Social Service Workers	6,590	6,882	123,167	17.90	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	36,781	17.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,092	29,872	282,417	9.45	15
16	Dishwashers					16
17	Maintenance Workers	7,117	7,676	100,870	13.14	17
18	Housekeepers	49,744	52,476	461,450	8.79	18
19	Laundry	8,521	9,107	77,323	8.49	19
20	Administrator	2,008	2,096	138,128	65.90	20
21	Assistant Administrator	1,392	1,504	52,982	35.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,136	21,046	363,092	17.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,747	4,059	61,212	15.08	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,148	6,581	89,264	13.56	31
32	Other Health Ca MDS	6,632	7,129	222,366	31.19	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	362,491	379,864	$ 5,660,762 *	$ 14.90	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	Monthly	$ 9,000	1-3	35
36	Medical Director	Monthly	62,500	9-3	36
37	Medical Records Consultant	26	1,500	10-3	37
38	Nurse Consultant	Monthly	62,722	10-3	38
39	Pharmacist Consultant	880	3,521	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	17	988	11-3	44
45	Social Service Consultant	25	1,416	12-3	45
46	Other(specify) Physicians	Monthly	4,797	10-3	46
47	Psychiatric	Monthly	212	10-3	47
48					48
49	TOTAL (lines 35 - 48)	948	$ 146,656		49

C. CONTRACT NURSES

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

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, L # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KAY P ROSS	ADMINISTRATOR	0	$ 75,293
BENJAMIN FRIEDMAN	ADMINISTRATOR	0	62,835
HELEN SICAT	ASST ADMIN	0	52,982
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 191,110

B. Administrative - Other

Description		Amount
DA WESTMONT	MANAGEMENT FEES	$ 894,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 894,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		146,891
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 146,891

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 164,767
Unemployment Compensation Insurance	89,093
FICA Taxes	427,518
Employee Health Insurance	102,320
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	121,562
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)	$ 905,260

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	$
Advertising: Employee Recruitment	13,295
Health Care Worker Background Check	1,640
(Indicate # of checks performed 41)	
Patient Background Checks 1	100
TRUST/FRANCHISE/CONTRIB/ETC	8,667
MARKETING/ADV/PROMO	34,089
LICENSES/DUES/SUBSCRIPTIONS	20,348
MGMT CO ALLOC	42
TRUST/FRANCHISE/CONTRIB/ETC	(8,667)
Less: Public Relations Expense	(0)
Non-allowable advertising	(34,089)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,425

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, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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													
9						N/A							
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WESTMONT NURSING AND REHAB CENTER, LLC # 0050120 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 $14,401**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **46,866** 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 fo
Schedule VII)? YES **YES** NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
WESTMONT CONVALESCENT CENTER, # 0030015 09/03/08

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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 othe
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
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? **YES**
Attach invoices and a summary of services for all architect and appraisal fees