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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0005249

Facility Name: THE WESTWOOD MANOR

Address: 2444 WEST TOUHY AVE (Number) CHICAGO (City) 60645 (Zip Code)

County: COOK

Telephone Number: (773) 274-7705 **Fax #** (773) 274-6173

HFS ID Number:

Date of Initial License for Current Owners: 1960

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **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 01/01/2014 to 12/31/2014 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) JOSEPH LIBERMAN
(Title) EXECUTIVE DIRECTOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	89	Intermediate (ICF)	89	32,485	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	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			451	451	8
9	SNF/PED					9
10	ICF	35,500	412		35,912	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,500	412	451	36,363	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.63%

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 1960

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 451

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	201,513	108,344	28,393	338,250		338,250		338,250			1
2	Food Purchase		251,698		251,698		251,698		251,698			2
3	Housekeeping	91,060	68,232		159,292		159,292		159,292			3
4	Laundry		4,345	1,653	5,998		5,998		5,998			4
5	Heat and Other Utilities			88,591	88,591		88,591		88,591			5
6	Maintenance		56,419	20,519	76,938		76,938		76,938			6
7	Other (specify):*			12,356	12,356		12,356		12,356			7
8	TOTAL General Services	292,573	489,038	151,512	933,123		933,123		933,123			8
	B. Health Care and Programs											
9	Medical Director			1,100	1,100		1,100		1,100			9
10	Nursing and Medical Records	1,156,405	79,363	25,330	1,261,098		1,261,098		1,261,098			10
10a	Therapy											10a
11	Activities	49,218	22,898	2,466	74,582		74,582		74,582			11
12	Social Services	99,039			99,039		99,039		99,039			12
13	CNA Training											13
14	Program Transportation			865	865		865		865			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,304,662	102,261	29,761	1,436,684		1,436,684		1,436,684			16
	C. General Administration											
17	Administrative	224,298			224,298		224,298		224,298			17
18	Directors Fees			32,388	32,388		32,388		32,388			18
19	Professional Services			75,394	75,394		75,394		75,394			19
20	Dues, Fees, Subscriptions & Promotions			101,235	101,235		101,235	(72,175)	29,060			20
21	Clerical & General Office Expenses	56,250	13,280	33,920	103,450		103,450	(1,224)	102,226			21
22	Employee Benefits & Payroll Taxes			357,094	357,094		357,094		357,094			22
23	Inservice Training & Education			1,240	1,240		1,240		1,240			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,389	1,389		1,389		1,389			25
26	Insurance-Prop.Liab.Malpractice			82,137	82,137		82,137		82,137			26
27	Other (specify):*											27
28	TOTAL General Administration	280,548	13,280	684,797	978,625		978,625	(73,399)	905,226			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,877,783	604,579	866,070	3,348,432		3,348,432	(73,399)	3,275,033			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#: THE WESTWOOD MANOR **#0005249** **Report Period Beginning: 01/01/2014** **Ending: 12/31/2014**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	22,506	
	REPAIRS & MAINTENANCE		5,887	
				28,393
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,653	
				1,653
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		28,778	
	ELECTRICITY		35,899	
	WATER		21,096	
	CABLE TV - LOBBY		2,818	
				88,591
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,530	
	PAINTING & DECORATING		3,077	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		3,562	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,250	
	FIRE SERVICE		6,100	
				20,519
7	**OTHER**			
	SCAVENGER		12,356	
	SECURITY SERVICE		0	
				12,356
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,100	1,100

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	6,314	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	9,184	
	PHARMACY CONSULTANT	XVIII B 39-2	9,832	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				25,330
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,466	
				2,466
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number THE WESTWOOD MANOR **#0005249** **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		865	
				865
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		32,388	32,388
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	48,550	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	26,844	
				75,394
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	72,000	
	EMPLOYEE WANT ADS	XIX F	24,150	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	0	
	LICENSES & PERMITS	XIX F	2,500	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	175	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,400	
	PATIENT BACKGROUND CHECKS	XIX F	1,010	
				101,235
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		5,248	
	EQUIPMENT REPAIR & MAINTENANCE		16,816	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,224	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		10,632	
	MESSENGER SERVICE		0	
				33,920

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	142,449	
	UNEMPLOYMENT COMPENSATION	XIX D	42,250	
	WORKERS COMPENSATION INSURANC	XIX D	34,273	
	HOSPITALIZATION INSURANCE	XIX D	134,820	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,302	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
				357,094
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,240	
				1,240
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,389	
				1,389
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		82,137	
				82,137
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **866,070**

THE WESTWOOD MANOR
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	251,698
LESS SALES TAX	0
NET FOOD	251,698
TOTAL PATIENT CENSUS	36,363
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	109,089
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	109,089
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	109,089
NET FOOD	251,698
DIVIDE TOTAL MEALS/YEAR	109,089
COST PER MEAL	2.31
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number THE WESTWOOD MANOR #0005249 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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			86,175	86,175		86,175	(14,839)	71,336			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			67,280	67,280		67,280	(3,485)	63,795			32
33	Real Estate Taxes			130,452	130,452		130,452		130,452			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,916	3,916		3,916		3,916			35
36	Other (specify):*											36
37	**TOTAL Ownership**			287,823	287,823		287,823	(18,324)	269,499			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		13,662	115,727	129,389		129,389		129,389			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			281,093	281,093		281,093		281,093			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		13,662	396,820	410,482		410,482		410,482			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,877,783	618,241	1,550,713	4,046,737		4,046,737	(91,723)	3,955,014			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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(14,839)	30		9
10	Interest and Other Investment Income	(3,485)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(175)	20		17
18	Fines and Penalties	(1,224)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(72,000)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (91,723)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (91,723)		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

THE WESTWOOD MANOR

ID# 0005249

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE WESTWOOD MANOR **#** 0005249 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(72,175)	0	0	0	0	0	0	0	0	0	0	(72,175)	20
21	Clerical & General Office Expenses	(1,224)	0	0	0	0	0	0	0	0	0	0	(1,224)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(73,399)	0	0	0	0	0	0	0	0	0	0	(73,399)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(73,399)	0	0	0	0	0	0	0	0	0	0	(73,399)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE WESTWOOD MANOR **#** 0005249 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(14,839)	0	0	0	0	0	0	0	0	0	0	(14,839)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,485)	0	0	0	0	0	0	0	0	0	0	(3,485)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,324)	0	0	0	0	0	0	0	0	0	0	(18,324)	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)**	(91,723)	0	0	0	0	0	0	0	0	0	0	(91,723)	45

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
SEE PAGE 6-SUPPLEMENTAL						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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	6		$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	CHAYA LIBERMAN	16.64						2
3	JOSEPH LIBERMAN	13.89						3
4	BETTY EBERT TRUST	13.89						4
5	MARLENE NADLER	27.79						5
6	ROSALIE EISENBERGER	24.67						6
7	ROSALIE EISENBERGER CUST. FOR							7
8	SHLOMO M. EISENBERGER	1.56						8
9	ROSALIE EISENBERGER CUST. FOR							9
10	YOSEF Z. EISENBERGER	1.56						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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JOSEPH LIBERMAN	EXECUTIVE DIR.	MANAGING	13.89		40	21.00	SALARY	$ 128,079	17-1	1
2	JOSEPH LIBERMAN	OUTSIDE DIRECT.	ADMINISTRAT	13.89		10	6.00	DIR FEES	4,858	18-3	2
3	BETTY EBERT TRUST	OUTSIDE DIRECT.	ADMINISTRAT	13.89		10	6.00	DIR FEES	4,858	18-3	3
4	MARLENE NADLER	OUTSIDE DIRECT.	ADMINISTRAT	27.79		20	11.00	DIR FEES	11,336	18-3	4
5	ROSALIE EISEMBERGER	OUTSIDE DIRECT.	ADMINISTRAT	24.67		20	11.00	DIR FEES	11,336	18-3	5
6	YAFA LIBERMAN	DIETARY	DIETARY	0.00		40	21.00	SALARY	21,168	1-1	6
7	CHAYA LIBERMAN	CLERICAL	CLERICAL	16.64		10	6.00	SALARY	4,950	21-1	7
8	CHAYA LIBERMAN	ADMINISTRATION	ADMINISTRAT	16.64		40	21.00	SALARY	21,168	17-1	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 207,753		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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB FINANCIAL	X		WORKING CAPITAL	$4,444.44	10/15/11	$ 800,000	$ 640,000	10/15/16	4.5000	$ 30,522	1
2												2
3	MB FINANCIAL	X		WORKING CAPITAL	$5,555.56	04/15/00	200,000		04/15/14	5.5000	535	3
4												4
5	MB FINANCIAL	X		WORKING CAPITAL	$8,046.56	06/05/13	873,133	515,123	06/05/18	5.0000	22,634	5
	Working Capital											
6	MB FINANCIAL	X		WORKING CAPITAL	DEMAND	REVOLV	800,000			PRIME+	11,478	6
7												7
8	FIRST INSURANCE	X		INSURANCE FINANCING							2,111	8
9	TOTAL Facility Related				$18,046.56		$ 2,673,133	$ 1,155,123			$ 67,280	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,673,133	$ 1,155,123			$ 67,280	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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 131,925	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.)		$ 132,387	2
3. Under or (over) accrual (line 2 minus line 1).		$ 462	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 133,740	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** $ 3,750 **For** 2010 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (3,750)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 130,452	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	120,790	8
	2010	112,046	9
	2011	111,580	10
	2012	130,619	11
	2013	132,387	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 2013 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE WESTWOOD MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0005249

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-427-035-0000	NURSING HOME	$ 121,829.45	$ 121,829.45
2.	10-25-427-010-0000	NURSING HOME	$ 10,557.49	$ 10,557.49
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 132,386.94	$ 132,386.94

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,250 B. General Construction Type: Exterior brick Frame _____ Number of Stories 1

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. [ ] (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	33,750	1960	$ 168,905	1
2					2
3	TOTALS	33,750		$ 168,905	3

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	115		1963	1960	$ 210,408	$		$	$	$ 210,408	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FULLY DEPRECIATED			1970	152,196					115,986	9
10	BUILDING REPAIR			1971	1,475					1,475	10
11	BUILDING REPAIR			1976	2,800					2,800	11
12	HEATING REPAIR			1980	4,222					4,222	12
13	ALARM			1980	3,500					3,500	13
14	ROOF			1981	13,500					13,500	14
15	PLUMBING REPAIRS			1982	5,956					5,956	15
16	FENCING			1982	860					860	16
17	PLUMBING REPAIRS			1983	29,055					29,055	17
18	BUILDING REPAIR			1983	4,770					4,770	18
19	TILE			1983	1,078					1,078	19
20	FURNITURE			1985	8,676					8,676	20
21	BUILDING IMPROVEMENTS			1986	3,533					3,533	21
22	WINDOW DRAPES			1986	15,402					15,402	22
23	TUCKPOINTING			1986	670					670	23
24	FURNITURE			1987	5,156					5,156	24
25	FURNITURE & IMPROVEMENTS			1988	2,183					2,183	25
26	ROOF			1988	30,900					30,900	26
27	PARKING LOT			1989	30,485					30,485	27
28	BUILDING IMPROVEMENTS			1990	2,650					2,650	28
29	HEATING IMPROVEMENTS			1990	217,945					217,945	29
30	ELECTRICAL SYSTEM			1990	27,757					27,757	30
31	VARIOUS IMPROVEMENTS			1990	14,588					14,588	31
32	FURNITURE			1991	76,838					76,838	32
33	REMODELING			1995	31,650					31,650	33
34	WINDOWS			1996	3,285					3,285	34
35	FIRE AND ALARM SYSTEM			1997	8,608					8,608	35
36	FLOOR TILE			1997	25,865					25,865	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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	AIRCONDITIONER	1997	$ 18,962	$		$	$	$ 18,962	37
38	REMODELING ROOMS	1997	6,234					6,234	38
39	BLACKTOP,TILING BATHROOMS	1998	5,582					5,582	39
40	PARTITIONS	1999	4,225					4,225	40
41	HVAC SYSTEM REPAIR	2000	13,496		20	655	655	10,025	41
42	FENCE	2002	1,464	87	15	87		1,192	42
43	REMODELING BATHROOMS	2002	8,858	322	27.5	322		4,012	43
44	PARKING LOT PAVING	2004	4,180		10			4,180	44
45	DOORS	2004	2,340	58	10		(58)	2,340	45
46	ROOFING	2004	6,000	96	10		(96)	6,000	46
47	KITCHEN REMODELING	2005	86,513	3,146	27.5	3,146		31,329	47
48	ELEVATOR REPAIR	2005	10,500	700	15	700		6,650	48
49	DOORS	2006	1,288	129	10	129		1,080	49
50	AIRCONDITIONER REPAIRS	2006	3,727		5			3,727	50
51	FLOORING	2006	130,000	4,727	27.5	4,727		38,801	51
52	NURSES CALL SYSTEM	2006	6,000		5			6,000	52
53	BATHROOMS REMODELING	2007	9,000	327	27.5	327		2,548	53
54	TUCKPOINTING	2007	4,000	145	27.5	145		1,069	54
55	AWNING	2007	4,845	176	27.5	176		1,401	55
56	INSTALL NEW SINGLE PLY MODIFIED BUTUMEN ROOF	2008	67,000	2,436	27.5	2,436		16,139	56
57	INSTALL DOMESTIC WATER SYSTEM BOOSTER PUMP	2008	12,000	436	27.5	436		2,634	57
58	REPAIR HVAC SYSTEM	2008	6,650		5			6,650	58
59	INSTALLED NEW FAN MOTOR & CYCLING CONTROL	2009	5,397	196	27.5	196		1,070	59
60	INSTALLED 2 NEW BOILERS	2009	41,950	1,525	27.5	1,525		7,689	60
61	CUBICAL CURTAIN	2009	3,253	95	5	95		3,253	61
62	INSTALLATION OF FIRE ALARM SYSTEM DEVICES	2010	17,959	653	27.5	653		3,129	62
63	REMODEL BATHROOM #111 WITH NEW TILE FLOOR	2010	4,550	165	27.5	165		763	63
64	INSTALL 28 COUNTER TOPS	2010	5,323	194	27.5	194		833	64
65	PAINTING OF CABINETS	2010	21,661	2,495	5	2,495		20,413	65
66	NEW GRRENHOUSE-INSTALLATION OF FOUNDATION,	2010	46,805	1,702	27.5	1,702		7,304	66
67	LEVELING BASE WALL & TUBULAR FRAMING, SOLAR								67
68	SHEETING ON EXTERIOR, REPAIR AND SEALING FLOOR,								68
69	INSTALLING ROUGH ELECTRIC AND LIGHTING								69
70	TOTAL (lines 4 thru 69)		$ 1,495,773	$ 19,810		$ 20,311	$ 501	$ 1,125,035	70

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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 1,495,773	$ 19,810		$ 20,311	$ 501	$ 1,125,035	1
2	INSTALL NEW THERMOSTAT, CHAHGE OVER SWITCHES	2010	27,096	985	27.5	985		3,899	2
3	INSTALL NEW MIXING VALVES IN TUB & SHOWER ROOM	2011	11,113	404	27.5	404		1,599	3
4	BUILD NEW STORAGE SHED INCLUDES FIBERGLASS,								4
5	SHINGLES AND VINYL SIDING WITH TWO DOORS	2011	9,370	341	27.5	341		1,236	5
6	REMODEL RECEPTION AREA: INSTALL DROPPED CELLING,								6
7	LIGHTS, FAN,COUNTER TOPS,CHAIR RAIL,NEW SHELVING								7
8	UNIT, SWITCHES AND OUTLETS, PAINTING WALLS	2011	14,864	541	27.5	541		1,961	8
9	COURT YARD: INSTALL ASPHALT SURFACE; PATCH								9
10	MAIN PARKING LOT AREA:INSTALL BITUMINOUS								10
11	SURFACE, ROLL AND COMPACT,GRIND BUTT JOINTS;								11
12	SEALCOAT ASPHALT PAVEMEN	2011	12,405	827	15	827		2,895	12
13	INSTALL NEW PUMP CONTOLLER	2011	4,600	167	27.5	167		564	13
14	BUILD NEW CONCRETE SIDEWALK, INSTALL METAL POS	2011	5,588	373	15	373		1,181	14
15	ADDITION OF SPRINKLER HEADS IN SKY LIGHTS	2011	2,520	92	27.5	92		288	15
16	RELOCATION OF WIRES TO PREVENT FLOOD DAMAGE	2011	5,000	182	27.5	182		569	16
17	BATHROOM-DEMO SHOWER WALLS AND FLOOR	2012	6,405	233	27.5	233		612	17
18	FURNISH & INSTALL NEW 2 TON AIR CONDITION UNIT	2012	7,000	255	27.5	255		691	18
19	LIGHTING RETROFIT TO INCREASE THE ENERGY EFFICII	2012	14,242	518	27.5	518		1,317	19
20	WINDOW TREATMENTS INSTALLATION	2012	3,570	685	5	685		2,541	20
21	SEALCOATING OF THE PARKING LOT	2012	2,945	196	15	196		457	21
22	INSTALL ADDITIONAL SUBPANEL(RESIDENTIAL GRADE)	2012	4,250	155	27.5	155		342	22
23	KITCHEN POT AND PAN AREA: DEMO DRYWALL,ROD	2012	10,921	397	27.5	397		844	23
24	DRAINS, DEMO FIRING STRIPS,DEMO MARLITE WALL								24
25	WIRING CIRCUITS FOR SIX ROOMS; INSTALLING NEW	2012	3,200	116	27.5	116		237	25
26	RECEPTACLES AND PLATES								26
27	FURNISH & INSTALL HOLLOW METAL PEDESTRIAN DOOR								27
28	AND FRAME	2013	8,700	316	27.5	316		619	28
29	CURTAINS RECOVERED AND COMPLETE AND INSTALLED	2013	3,170	115	27.5	115		168	29
30	INSTALLING OUTDOOR FIXTURES AND RECEPTACLES IN								30
31	RECORDS & MEETING ROOM; NEW EXIT SIGNS	2013	4,100	273	15	273		387	31
32	FIRE ALARM SYSTEM DEVICES: REPLACED TAMPER PANEL								32
33	AND ANNUNCIATOR	2013	2,832	103	27.5	103		133	33
34	TOTAL (lines 1 thru 33)		$ 1,659,664	$ 27,084		$ 27,585	$ 501	$ 1,147,575	34

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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 1,659,664	$ 27,084		$ 27,585	$ 501	$ 1,147,575	1
2	GARDEN BEDS FOR RESIDENTS:BUILDING OF 4 RAISED								2
3	BED GARDEN & ONE WHEELCHAIR ACCESSIBLE BED	2013	13,220	881	15	881		954	3
4	REMODELING : REPLACEMENT FAN COIL UNITS, INSTALLED								4
5	NEW FLUSH MOUNT FAN COIL UNITS IN CENTER OF.								5
6	DINING ROOM, NEW HOT WATER CHILLED WATER PIPING,								6
7	NEW CONDENSATE DRAIN PUMPS FOR FAN COIL UNITS,								7
8	NEW ROOF CURBS, NEW SUPPLY DUCTING, DIFFUSERS,								8
9	REWORKED SPRINKLER SYSTEM IN FIVE BATHROOM	2013	92,565	3,366	27.5	3,366		3,506	9
10	FRONT ENTRANCE, DINING ROOM,ALL HALLWAYS,								10
11	CONFERENCE ROOM, THERAPY ROOM, RESIDENT ROOMS								11
12	& BATHROOMS:INSTALL NEW FRAMING, DRYWALL,								12
13	CHAIR MOLDING, PANELING AND VANIL BASE, PAINTING								13
14	CEILING AND WALLS, DOOR AND WALL CORNERS	2013	238,015	8,655	27.5	8,655		9,016	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,003,464	$ 39,986		$ 40,487	$ 501	$ 1,161,051	34

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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 259,303	$ 11,143	$ 26,453	$ 15,310	5-10	$ 145,011	71
72	Current Year Purchases	55,618	33,371	4,396	(28,975)	5-10	4,396	72
73	Fully Depreciated Assets	278,391					278,391	73
74								74
75	TOTALS	$ 593,312	$ 44,514	$ 30,849	$ (13,665)		$ 427,798	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	FACILITY	2066 CHRYSLER VAN	2005	$ 43,880	$ 1,675	$	$ (1,675)		$ 43,880	76
77										77
78										78
79										79
80	TOTALS			$ 43,880	$ 1,675	$	$ (1,675)		$ 43,880	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)	$ 2,809,561	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,175	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 71,336	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (14,839)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,632,729	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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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: $ 3,916 Description: COPIER MACHINE
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$		$ 43,144	$		$ 43,144	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			16,254			16,254	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			56,329			56,329	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				13,662		13,662	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 115,727	$ 13,662		$ 129,389	14

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

STATE OF ILLINOIS

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 118,136	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	726,218		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,133		6
7	Other Prepaid Expenses	10,880		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): REAL ESTATE ESCROW	66,701		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,005,068	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	168,905		13
14	Buildings, at Historical Cost	159,277		14
15	Leasehold Improvements, at Historical Cost	1,819,292		15
16	Equipment, at Historical Cost	658,581		16
17	Accumulated Depreciation (book methods)	(1,671,014)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,135,041	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,140,109	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 376,818	$	26
27	Officer's Accounts Payable	93,494		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	515,123		29
30	Accrued Salaries Payable	21,556		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,977		31
32	Accrued Real Estate Taxes(Sch.IX-B)	133,740		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,170,708	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	640,000		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)**	$ 640,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,810,708	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 329,401	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,140,109	$	48

***(See instructions.)**

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 203,834	1
2	Restatements (describe):		2
3	ROUNDING	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 203,840	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	365,561	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	(240,000)	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)**	$ 125,561	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)**	$ 329,401	24 *

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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,410,778	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,410,778	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,485	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,485	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,414,263	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	933,123	31
32	Health Care	1,436,684	32
33	General Administration	978,625	33
	B. Capital Expense		
34	Ownership	287,823	34
	C. Ancillary Expense		
35	Special Cost Centers	129,389	35
36	Provider Participation Fee	281,093	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,046,737	40
41	**Income before Income Taxes (line 30 minus line 40)****	367,526	41
42	**Income Taxes**	(1,965)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 365,561	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,074,338	44
45	Private Pay - Net Inpatient Revenue	53,560	45
46	Medicare - Net Inpatient Revenue	282,880	46
47	Other-(specify) HOSPICE/INSURANCE/ETC		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,410,778	49

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

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

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

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

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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
2	Assistant Director of Nursing					2
3	Registered Nurses	11,100	11,702	346,656	29.62	3
4	Licensed Practical Nurses	11,471	12,514	309,896	24.76	4
5	CNAs & Orderlies	43,417	46,579	499,853	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,928	5,222	49,218	9.43	10
11	Social Service Workers	6,930	7,211	99,039	13.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,390	18,260	201,513	11.04	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	8,334	9,323	91,060	9.77	18
19	Laundry					19
20	Administrator	2,160	2,160	128,079	59.30	20
21	Assistant Administrator					21
22	Other Administrative	3,520	3,712	96,219	25.92	22
23	Office Manager					23
24	Clerical	6,050	6,214	56,250	9.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,300	122,897	$ 1,877,783 *	$ 15.28	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	M	$ 22,506	1-3	35
36	Medical Director	O	1,100	9-3	36
37	Medical Records Consultant	N	9,184	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,832	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,466	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 45,088		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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOSEPH LIBERMAN	OFFICER	12.50	$ 128,079
YVONNE EDWARD-THOMAS	ADMINISTRATION	0	73,127
CHAYA LIBERMAN	ADMINISTRATION	16.64	21,168
SUSAN VASQUEZ	ADMINISTRATION	0	1,924
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 224,298

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		75,394
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 75,394

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,273
Unemployment Compensation Insurance	42,250
FICA Taxes	142,449
Employee Health Insurance	134,820
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3,302
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 357,094

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	24,150
Health Care Worker Background Check	1,400
(Indicate # of checks performed 40)	
Patient Background Checks 60	1,010
TRUST/FRANCHISE/CONTRIB/ETC	175
MARKETING/ADV/PROMO	72,000
LICENSES/DUES/SUBSCRIPTIONS	510
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(175)
Less: Public Relations Expense	(0)
Non-allowable advertising	(72,000)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,060

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 THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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							N/A						
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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. $ **10,816** 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 NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **281,093**
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 out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.