

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0005249

Facility Name: THE WESTWOOD MANOR

Address: 2444 WEST TOUHY AVENUE CHICAGO 60645
Number City 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
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ 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 01/01/2012 to 12/31/2012 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) 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 THE WESTWOOD MANOR# 0005249 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>26</u>	Skilled (SNF)	<u>26</u>	<u>9,516</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>89</u>	Intermediate (ICF)	<u>89</u>	<u>32,574</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	42,090	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>331</u>	<u>331</u>	8
9	SNF/PED					9
10	ICF	<u>38,084</u>	<u>438</u>		<u>38,522</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,084	438	331	38,853	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.31%

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?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 1960

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date _____

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 26 and days of care provided 331Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	195,136	135,731	30,835	361,702		361,702		361,702			1
2	Food Purchase		222,545		222,545		222,545		222,545			2
3	Housekeeping	92,853	43,988		136,841		136,841		136,841			3
4	Laundry		13,629	1,315	14,944		14,944		14,944			4
5	Heat and Other Utilities			73,690	73,690		73,690		73,690			5
6	Maintenance		41,844	15,956	57,800		57,800		57,800			6
7	Other (specify):*			10,512	10,512		10,512		10,512			7
8	TOTAL General Services	287,989	457,737	132,308	878,034		878,034		878,034			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,112,892	65,237	13,502	1,191,631		1,191,631		1,191,631			10
10a	Therapy											10a
11	Activities	39,938	21,832	2,352	64,122		64,122		64,122			11
12	Social Services	187,226		26,410	213,636		213,636		213,636			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,340,056	87,069	49,464	1,476,589		1,476,589		1,476,589			16
	C. General Administration											
17	Administrative	128,430			128,430		128,430		128,430			17
18	Directors Fees			22,666	22,666		22,666		22,666			18
19	Professional Services			42,022	42,022		42,022		42,022			19
20	Dues, Fees, Subscriptions & Promotions			19,558	19,558		19,558	(5,406)	14,152			20
21	Clerical & General Office Expenses	93,079	19,782	19,015	131,876		131,876	(265)	131,611			21
22	Employee Benefits & Payroll Taxes			353,287	353,287		353,287		353,287			22
23	Inservice Training & Education			3,320	3,320		3,320		3,320			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,797	1,797		1,797		1,797			25
26	Insurance-Prop.Liab.Malpractice			72,271	72,271		72,271		72,271			26
27	Other (specify):*											27
28	TOTAL General Administration	221,509	19,782	533,936	775,227		775,227	(5,671)	769,556			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,849,554	564,588	715,708	3,129,850		3,129,850	(5,671)	3,124,179			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	22,827
	REPAIRS & MAINTENANCE		8,008
			0
			30,835
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		1,315
			0
			1,315
5	HEAT & OTHER UTILITIES		
	GAS HEAT		20,621
	ELECTRICITY		31,673
	WATER		19,385
	CABLE TV - LOBBY		2,011
			0
			73,690
6	MAINTENANCE		
	GROUNDS MAINTENANCE		2,921
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		2,754
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		4,314
	FIRE SERVICE		5,967
			0
			0
			0
			0
			15,956
7	OTHER		
	SCAVENGER		10,512
	SECURITY SERVICE		0
			0
			0
			10,512
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,200
			7,200

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	9,649
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,555
	PHARMACY CONSULTANT	XVIII B 39-2	1,298
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			13,502
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 CONSULTANT	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT	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	2,352
			0
			2,352
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	26,410
			26,410
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
		0	
17	ADMINISTRATIVE		
	MANAGEMENT FEES XIX B	0	0
	DIRECTORS FEES		
18	DIRECTORS FEES	22,666	22,666
19	PROFESSIONAL SERVICES		
	DATA PROCESSING XIX C	6,314	
	ADMINISTRATIVE CONSULTANTS XIX C	4,200	
	PROFESSIONAL FEES XIX C	31,508	
		0	42,022
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0	
	EMPLOYEE WANT ADS XIX F	5,000	
	CONTRIBUTIONS VI 20 XIX F	1,000	
	DUES & SUBSCRIPTIONS XIX F	7,449	
	LICENSES & PERMITS XIX F	823	
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	461	
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,945	
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	754	
	PATIENT BACKGROUND CHECKS XIX F	126	
			19,558
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,412	
	EQUIPMENT REPAIR & MAINTENANCE	5,080	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES VI 18	265	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	7,258	
	MESSENGER SERVICE	0	
		0	19,015

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES XIX D	140,358	
	UNEMPLOYMENT COMPENSATION XIX D	23,747	
	WORKERS COMPENSATION INSURANC XIX D	31,579	
	HOSPITALIZATION INSURANCE XIX D	154,659	
	EMPLOYEE BENEFITS - OTHER XIX D	2,944	
	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	
		0	353,287
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	3,320	
			3,320
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS XIX G		
	TRAVEL XIX G	0	
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	1,797	
			1,797
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	72,271	
			72,271
27	OTHER		
	BAD DEBTS VI 24	0	
			0

GRAND TOTAL COLUMN 3 OTHER

715,708

THE WESTWOOD MANOR
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	222,545	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	222,545	
TOTAL PATIENT CENSUS	38,853	
TIMES 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	116,559	
ADD # EMPLOYEE MEALS/DAY		
TIMES # DAYS	<u>366</u>	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	116,559	
ADD EMPLOYEE MEALS	<u>0</u>	
TOTAL MEALS/YEAR	116,559	
NET FOOD	222,545	
DIVIDE TOTAL MEALS/YEAR	<u>116,559</u>	
COST PER MEAL	1.91	
TIMES EMPLOYEE MEALS	<u>0</u>	
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>	

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			61,868	61,868		61,868	(6,280)	55,588			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,464	70,464		70,464	(1,304)	69,160			32
33	Real Estate Taxes			102,002	102,002		102,002		102,002			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,030	4,030		4,030		4,030			35
36	Other (specify):*											36
37	TOTAL Ownership			238,364	238,364		238,364	(7,584)	230,780			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,124	31,535	34,659		34,659		34,659			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			420,417	420,417		420,417		420,417			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		3,124	451,952	455,076		455,076		455,076			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,849,554	567,712	1,406,024	3,823,290		3,823,290	(13,255)	3,810,035			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,280)	30		9
10	Interest and Other Investment Income	(1,304)	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	(461)	20		17
18	Fines and Penalties	(265)	21		18
19	Entertainment		20		19
20	Contributions	(4,945)	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		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)	\$ (13,255)		\$	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
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (13,255)		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

STATE OF ILLINOIS
THE WESTWOOD MANOR

Page 5A

Report Period Beginning: ID# 0005249
Ending: 01/01/2012
12/31/2012

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:

01/01/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	(5,406)	0	0	0	0	0	0	0	0	0	0	(5,406)	20
21	Clerical & General Office Expenses	(265)	0	0	0	0	0	0	0	0	0	0	(265)	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	(5,671)	0	0	0	0	0	0	0	0	0	0	(5,671)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(5,671)	0	0	0	0	0	0	0	0	0	0	(5,671)	29

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	(6,280)	0	0	0	0	0	0	0	0	0	0	(6,280)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,304)	0	0	0	0	0	0	0	0	0	0	(1,304)	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	(7,584)	0	0	0	0	0	0	0	0	0	0	(7,584)	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)	(13,255)	0	0	0	0	0	0	0	0	0	0	(13,255)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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:

01/01/2012

Ending:

12/31/2012

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	25.00						2
3	JOSEPH LIBERMAN	12.50						3
4	BETTY EBERT TRUST	12.50						4
5	MARLENE NADLER	25.00						5
6	ROSALIE EISENBERGER	22.20						6
7	ROSALIE EISENBERGER CUST. FOR							7
8	SHLOMO M. EISENBERGER	1.40						8
9	ROSALIE EISENBERGER CUST. FOR							9
10	YOSEF Z. EISENBERGER	1.40						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: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JOSEPH LIBERMAN	EXECUTIVE DIR.	MANAGING	12.50	0	40	100.00	SALARY	\$ 128,430	17-1	1
2	MARLENE NADLER	OUTSIDE DIRECT.	ADMINISTRAT	25.00	0	20	20.00	DIR FEES	11,333	18-3	2
3	ROSALIE EISEMBERGER	OUTSIDE DIRECT.	ADMINISTRAT	22.20	0	20	20.00	DIR FEES	11,333	18-3	3
4	Yafa LIBERMAN	DIETARY	DIETARY	0.00	0	40	100.00	SALARY	19,500	1-1	4
5	CHAYA LIBERMAN	CLERICAL	CLERICAL	25.00	0	40	100.00	SALARY	35,591	21-1	5
6	MARLENE NADLER	ADM CONSULTAN	CONSULT	25.00	0	20	20.00	ADM CONS	4,200	19-3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 210,387		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: 01/01/2012 Ending: 2/31/2012

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

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	\$7,372.22	10/15/11	\$ 800,000	\$ 746,667	10/15/16	4.5000	\$ 35,586	1	
2												2	
3	MB FINANCIAL		X	WORKING CAPITAL	\$5,555.56	04/15/11	200,000	101,365	04/15/14	5.5000	7,517	3	
4												4	
5												5	
	Working Capital												
6	MB FINANCIAL	X		WORKING CAPITAL	DEMAND	REVOLV	800,000	390,249	REVOLV	5.2500	26,307	6	
7	FIRST INSURANCE	X		INSURANCE FINANCING							1,054	7	
8												8	
9	TOTAL Facility Related				\$12,927.78		\$ 1,800,000	\$ 1,238,281			\$ 70,464	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,800,000	\$ 1,238,281			\$ 70,464	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	113,166	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.)		\$	111,580	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,586)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	112,696	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 \$ 9,108 For 2008 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(9,108)	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	102,002	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	120094	8	
		2008	120,004	9	
		2009	120,790	10	
		2010	112,046	11	
		2011	111,580	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 2011 TAX BILL.					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
THE WESTWOOD MANOR

COUNTY
COOK

FACILITY IDPH LICENSE NUMBER
0005249

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 2011 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 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	10-25-427-035-0000	NURSING HOME	\$ 102,173.40	\$ 102,173.40
2.	10-25-427-010-0000	NURSING HOME	\$ 9,406.44	\$ 9,406.44
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 111,579.84	\$ 111,579.84

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,250

B. General Construction Type: Exterior BRICK

Frame

Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? ☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	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:

01/01/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		15	2,341	2,341	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:

01/01/2012 Ending: 12/31/2012

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	8,715	41
42	FENCE	2002	1,464	87	15	87		1,019	42
43	REMODELING BATHROOMS	2002	8,858	322	27.5	322		3,368	43
44	PARKING LOT PAVING	2004	4,180		10	418	418	3,762	44
45	DOORS	2004	2,340	117	10	234	117	2,106	45
46	ROOFING	2004	6,000	197	10	600	403	5,400	46
47	KITCHEN REMODELING	2005	86,513	3,146	27.5	3,146		25,037	47
48	ELEVATOR REPAIR	2005	10,500	700	15	700		5,250	48
49	DOORS	2006	1,288	129	10	129		822	49
50	AIRCONDITIONER REPAIRS	2006	3,727		5			3,727	50
51	FLOORING	2006	130,000	4,727	27.5	4,727		29,347	51
52	NURSES CALL SYSTEM	2006	6,000		5			6,000	52
53	BATHROOMS REMODELING	2007	9,000	327	27.5	327		1,894	53
54	TUCKPOINTING	2007	4,000	145	27.5	145		779	54
55	AWNING	2007	4,845	176	27.5	176		1,049	55
56	INSTALL NEW SINGLE PLY MODIFIED BUTUMEN ROOF	2008	67,000	2,436	27.5	2,436		11,267	56
57	INSTALL DOMESTIC WATER SYSTEM BOOSTER PUMP	2008	12,000	436	27.5	436		1,762	57
58	REPAIR HVAC SYSTEM	2008	6,650	766	5	766		6,267	58
59	INSTALLED NEW FAN MOTOR & CYCLING CONTROL	2009	5,397	196	27.5	196		678	59
60	INSTALLED 2 NEW BOILERS	2009	41,950	1,525	27.5	1,525		4,639	60
61	CUBICAL CURTAIN	2009	3,253	187	5	187		2,971	61
62	INSTALLATION OF FIRE ALARM SYSTEM DEVICES	2010	17,959	653	27.5	653		1,823	62
63	REMODEL BATHROOM #111 WITH NEW TILE FLOOR	2010	4,550	165	27.5	165		433	63
64	INSTALL 28 COUNTER TOPS	2010	5,323	194	27.5	194		445	64
65	PAINTING OF CABINETS	2010	21,661	4,159	5	4,159		15,423	65
66	NEW GRRENHOUSE-INSTALLATION OF FOUNDATION,	2010	46,805	1,702	27.5	1,702		3,900	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	\$ 22,492		\$ 26,426	\$ 3,934	\$ 1,082,687	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:

01/01/2012 Ending: 12/31/2012

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	\$ 22,492		\$ 26,426	\$ 3,934	\$ 1,082,687	1
2	INSTALL NEW THERMOSTAT, CHAHGE OVER SWITCHES	2010	27,096	985	27.5	985		1,929	2
3	INSTALL NEW MIXING VALVES IN TUB & SHOWER ROOM	2011	11,113	404	27.5	404		791	3
4	BUILD NEW STORAGE SHED INCLUDES FIBERGLASS,								4
5	SHINGLES AND VINYL SIDING WITH TWO DOORS	2011	9,370	341	27.5	341		554	5
6	REMODEL RECEPTION AREA: INSTALL DROPPED CELLING,								6
7	LIGHTS, FAN,COUNTER TOPS,CHAIR RAIL,NEW SHELIVING								7
8	UNIT, SWITCHES AND OUTLETS, PAINTING WALLS	2011	14,864	541	27.5	541		879	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		1,241	12
13	INSTALL NEW PUMP CONTOLLER	2011	4,600	167	27.5	167		230	13
14	BUILD NEW CONCRETE SIDEWALK, INSTALL METAL POS	2011	5,588	373	15	373		435	14
15	ADDITION OF SPRINKLER HEADS IN SKY LIGHTS	2011	2,520	92	27.5	92		104	15
16	RELOCATION OF WIRES TO PREVENT FLOOD DAMAGE	2011	5,000	182	27.5	182		205	16
17	BATHROOM-DEMO SHOWER WALLS AND FLOOR	2012	6,405	146	27.5	146		146	17
18	FURNISH & INSTALL NEW 2 TON AIR CONDITION UNIT	2012	7,000	181	27.5	181		181	18
19	LIGHTING RETROFIT TO INCREASE THE ENERGY EFFICI	2012	14,242	281	27.5	281		281	19
20	WINDOW TREATMENTS INSTALLATION	2012	3,570	714	5	714		714	20
21	SEALCOATING OF THE PARKING LOT	2012	2,945	65	15	65		65	21
22	INSTALL ADDITIONAL SUBPANEL(RESIDENTIAL GRADE)	2012	4,250	32	27.5	32		32	22
23	KITCHEN POT AND PAN AREA: DEMO DRYWALL,ROD	2012	10,921	50	27.5	50		50	23
24	DRAINS, DEMO FIRING STRIPS,DEMO MARLITE WALL								24
25	WIRING CIRCUITS FOR SIX ROOMS; INSTALLING NEW	2012	3,200	5	27.5	5		5	25
26	RECEPTACLES AND PLATES								26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,640,862	\$ 27,878		\$ 31,812	\$ 3,934	\$ 1,090,529	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 207,890	\$ 8,260	\$ 20,788	\$ 12,528	10	\$ 103,150	71
72	Current Year Purchases	40,091	24,055	2,983	(21,072)	5-10	2,983	72
73	Fully Depreciated Assets	263,900					263,900	73
74								74
75	TOTALS	\$ 511,881	\$ 32,315	\$ 23,771	\$ (8,544)		\$ 370,033	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	2006 CHRYSLER VAN	2005	\$ 43,880	\$ 1,675	\$ 5	\$ (1,670)		\$ 43,880	76
77										77
78										78
79										79
80	TOTALS			\$ 43,880	\$ 1,675	\$ 5	\$ (1,670)		\$ 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)	\$ 2,365,528	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,868	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,588	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,280)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,504,442	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$4,030 Description: COPIER MACHINE
- ☐ YES☒ NO
- (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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
Fiscal Year EndingAnnual Rent
12. \$
13. \$
14. \$

* 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.

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
☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 14,959	\$		\$ 14,959	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			874			874	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			15,702			15,702	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				3,124		3,124	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			\$		\$ 31,535	\$ 3,124		\$ 34,659	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.

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	\$ 655,686	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	465,484		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,453		6
7	Other Prepaid Expenses	64,212		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>REAL ESTATE ESCROW</u>	61,625		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,330,460	\$	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	1,456,691		15
16	Equipment, at Historical Cost	577,150		16
17	Accumulated Depreciation (book methods)	(1,527,954)		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): <u>CONSTRUCTION ESCROW</u>	68,418		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 902,487	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,232,947	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 405,585	\$	26
27	Officer's Accounts Payable	93,494		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,238,281		29
30	Accrued Salaries Payable	83,117		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,546		31
32	Accrued Real Estate Taxes(Sch.IX-B)	112,696		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)	\$ 1,943,719	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,943,719	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 289,228	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,232,947	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 25,549	1
2	Restatements (describe):		2
3	PRIOR YEAR DISTRIBUTIONS	350,000	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 375,549	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	803,679	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	(890,000)	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)	\$ (86,321)	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)	\$ 289,228	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number THE WESTWOOD MANOR# 0005249Report Period Beginning: 01/01/2012Ending: 12/31/2012**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,568,972	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,568,972	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***	1,304	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,304	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)	\$ 4,570,276	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	878,034	31
32	Health Care	1,476,589	32
33	General Administration	775,227	33
	B. Capital Expense		
34	Ownership	238,364	34
	C. Ancillary Expense		
35	Special Cost Centers	34,659	35
36	Provider Participation Fee	420,417	36
	D. Other Expenses (specify):		
37	<u>OUT-OF-PERIOD EXPENSES-LEGAL FEES</u>	(56,693)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,766,597	40
41	Income before Income Taxes (line 30 minus line 40)**	803,679	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 803,679	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,324,905	44
45	Private Pay - Net Inpatient Revenue	54,750	45
46	Medicare - Net Inpatient Revenue	189,317	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,568,972	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. CASH RETURN PREPARED

*** 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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,525	7,118	239,029	33.58	3
4	Licensed Practical Nurses	13,187	14,347	359,545	25.06	4
5	CNAs & Orderlies	43,215	46,430	514,318	11.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,892	4,034	39,938	9.90	10
11	Social Service Workers	10,159	10,879	187,226	17.21	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	19,500	9.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,949	15,410	175,636	11.40	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	8,803	9,629	92,853	9.64	18
19	Laundry					19
20	Administrator	2,080	2,080	128,430	61.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,347	8,589	93,079	10.84	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)	112,237	120,596	\$ 1,849,554 *	\$ 15.34	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	331	\$ 22,827	1-3	35
36	Medical Director	Monthly Fee	7,200	9-3	36
37	Medical Records Consultant	Monthly Fee	2,555	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly Fee	1,298	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	48	2,352	11-3	44
45	Social Service Consultant	1,321	26,410	12-3	45
46	Other(specify)				46
47	Psycho-Social	128	9,649	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,828	\$ 72,291		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
JOSEPH LIBERMAN	ADMINISTRATOR	12.5	\$ 128,430	Workers' Compensation Insurance		\$ 31,579	IDPH License Fee		\$		
				Unemployment Compensation Insurance		23,747	Advertising: Employee Recruitment		5,000		
				FICA Taxes		140,358	Health Care Worker Background Check		754		
				Employee Health Insurance		154,659	(Indicate # of checks performed 12)				
				Employee Meals		0	Patient Background Checks	2	126		
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC		5,406		
				EMPLOYEE BENEFITS - OTHER		2,944	MARKETING/ADV/PROMO		0		
				EMPLOYEE PHYSICAL EXAMS		0	LICENSES/DUES/SUBSCRIPTIONS		8,272		
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOC				
				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC		(5,406)		
				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(	0)		
				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(	0)		
							Yellow page advertising	(	0)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 128,430	TOTAL (agree to Schedule V, line 22, col.8)		\$ 353,287	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,152		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description		Amount		
			\$ 0			\$	Out-of-State Travel		\$		
							In-State Travel		0		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense		0		
C. Professional Services											
Vendor/Payee	Type		Amount								
ALPHA DATA SERVICE	DATA PROCESSING		\$ 4,107								
LTC SOLUTIONS	DATA PROCESSING		1,750								
PURCHASING PLUS	PURCHASING CONSULTANT		960								
KRUPNICK, BOKOR, KAGDA	ACCOUNTING		18,900								
IVAN'S	DATA PROCESSING		457								
ASHMAN & STEIN	LEGAL FFES		81								
ELLIOT M. SAMUELS	LEGAL FFES		4,138								
MARLENE NADLER	ADM. CONSULTANT		4,200								
MCCORMIC & WAGNER	APPRISER FEE		3,100								
MARVIN POER AND CO	TAX CONSULTING		2,659								
ELOISE LUBIN DESIGNS	INTERIOR DESIGN		1,670								
\			\				Entertainment Expense	(	)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 42,022	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$		

*** Attach copy of IMRF notifications**

****See instructions.**

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

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

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?
If YES, give association name and amount.

IL COUNCIL ON LONG TERM CARE \$7,199
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

YES
YES
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
10 YR
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 16,197 Line 10-2
- (7)

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

YES
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO
- (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)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 420,417
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

- (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?
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.

NO
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
N/A
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO
\$ N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

NO
- (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?
Attach invoices and a summary of services for all architect and appraisal fees.

N/A