

		FOR OHF USE					

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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.

<p>I. IDPH Facility ID Number: <u>0005249</u></p> <p>Facility Name: <u>THE WESTWOOD MANOR</u></p> <p>Address: <u>2444 W. TOUHY</u> <u>CHICAGO</u> <u>60645</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 274-7705</u> Fax # <u>(773) 274-6173</u></p> <p>IDPA ID Number: <u>36-2443231</u></p> <p>Date of Initial License for Current Owners: <u>1960</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:15%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>JOSEPH LIBERMAN</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>EXECUTIVE DIRECTOR</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date)		(Type or Print Name) <u>JOSEPH LIBERMAN</u>		(Title) <u>EXECUTIVE DIRECTOR</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date)		(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>		(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number THE WESTWOOD MANOR

0005249 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		365		365	8
9	SNF/PED					9
10	ICF	39,684			39,684	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,684	365		40,049	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.41%

D. How many bed-hold days during this year were paid by Public Aid?

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

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 _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	131,722		5,721	137,443		137,443	0	137,443		1
2	Food Purchase		147,790		147,790		147,790	0	147,790		2
3	Housekeeping	53,739	74,536	0	128,275		128,275	0	128,275		3
4	Laundry	0	731	0	731		731	0	731		4
5	Heat and Other Utilities			51,285	51,285		51,285	0	51,285		5
6	Maintenance	0		119,039	119,039		119,039	(9,102)	109,937		6
7	Other (specify):*			8,068	8,068		8,068	0	8,068		7
8	TOTAL General Services	185,461	223,057	184,113	592,631	0	592,631	(9,102)	583,529		8
	B. Health Care and Programs										
9	Medical Director	0		1,775	1,775		1,775	0	1,775		9
10	Nursing and Medical Records	764,738	13,350	2,032	780,120		780,120	0	780,120		10
10a	Therapy	0		861	861		861	0	861		10a
11	Activities	35,257	6,113	2,256	43,626		43,626	0	43,626		11
12	Social Services	86,526		6,864	93,390		93,390	0	93,390		12
13	Nurse Aide Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	886,521	19,463	13,788	919,772	0	919,772	0	919,772		16
	C. General Administration										
17	Administrative	182,715		0	182,715		182,715	0	182,715		17
18	Directors Fees			22,605	22,605		22,605	0	22,605		18
19	Professional Services			18,329	18,329		18,329	0	18,329		19
20	Dues, Fees, Subscriptions & Promotions			21,188	21,188		21,188	(3,823)	17,365		20
21	Clerical & General Office Expenses	58,828	13,603	7,401	79,832		79,832	0	79,832		21
22	Employee Benefits & Payroll Taxes			210,306	210,306		210,306	0	210,306		22
23	Inservice Training & Education			1,195	1,195		1,195	0	1,195		23
24	Travel and Seminar			0	0		0	0	0		24
25	Other Admin. Staff Transportation			4,553	4,553		4,553	0	4,553		25
26	Insurance-Prop.Liab.Malpractice			37,877	37,877		37,877	0	37,877		26
27	Other (specify):*			0	0		0	0	0		27
28	TOTAL General Administration	241,543	13,603	323,454	578,600	0	578,600	(3,823)	574,777		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,313,525	256,123	521,355	2,091,003	0	2,091,003	(12,925)	2,078,078		29

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

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

Facility Name & ID Number THE WESTWOOD MANOR

#0005249

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			61,890	61,890		61,890	21,067	82,957			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			1,260	1,260		1,260	(1,260)	0			32
33	Real Estate Taxes			89,814	89,814		89,814	0	89,814			33
34	Rent-Facility & Grounds			0	0		0	0	0			34
35	Rent-Equipment & Vehicles			0	0		0	0	0			35
36	Other (specify):*			0	0		0	0	0			36
37	TOTAL Ownership			152,964	152,964	0	152,964	19,807	172,771			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			0	0		0	0	0			38
39	Ancillary Service Centers			0	0		0	0	0			39
40	Barber and Beauty Shops			0	0		0	0	0			40
41	Coffee and Gift Shops			0	0		0	0	0			41
42	Provider Participation Fee			62,963	62,963		62,963	0	62,963			42
43	Other (specify):*			0	0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	62,963	62,963	0	62,963	0	62,963			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,313,525	256,123	737,282	2,306,930	0	2,306,930	6,882	2,313,812			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: 01/01/2001

Ending: 12/31/2001

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	21,067	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(1,260)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(100)	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(3,723)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	0	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(9,102)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 6,882		\$ 0	30

OHF 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	2	
		Amount	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)	0		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 0		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 6,882		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					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: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ -9102	6	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
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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	Total	(9,102)		48
49				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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	(9,102)	0	0	0	0	0	0	0	0	0	0	(9,102)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,102)	0	0	0	0	0	0	0	0	0	0	(9,102)	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	Nurse Aide 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	(3,823)	0	0	0	0	0	0	0	0	0	0	(3,823)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(3,823)	0	0	0	0	0	0	0	0	0	0	(3,823)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(12,925)	0	0	0	0	0	0	0	0	0	0	(12,925)	29

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

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

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

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: 01/01/2001 Ending: 12/31/2001

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	CHAYA LIBERMAN	ADMINISTRATOR	ADMINISTRTR.	0.25		40	40.00	SALARY	\$ 71,227	17-1	1
2	JOSEPH LIBERMAN	EXECUT. DIRECT.	MANAGING	0.13		40	40.00	SALARY	111,488	17-1	2
3	MARLENE NADLER	OUTSIDE DIRECT.	ADMINISTRTR.	0.22		20	20.00		11,303	18-3	3
4	ROSALIE EISEMBERGER	OUTSIDE DIRECT.	ADMINISTRTR.	0.01		20	20.00		11,303	18-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 205,321		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: 01/01/2001 Ending: 2/31/2001

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

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

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

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

Facility Name & ID Number

THE WESTWOOD MANOR

0005249

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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		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							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 0	\$ 0			\$ 0	9								
	B. Non-Facility Related*																			
10			X	AUTO LOAN							1,260	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 1,260	14								
15	TOTALS (line 9+line14)						\$ 0	\$ 0			\$ 1,260	15								

* 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: 01/01/2001 Ending: 12/31/2001

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	126,640	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.)			\$	103,073	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(23,567)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	113,381	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	89,814	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996	108,337	8	
		1997	123,597	9	
		1998	125,790	10	
		1999	124,946	11	
		2000	103,073	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 110% OF THE PRIOR YEAR REAL ESTATE TAX BILL.					
THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.					
		FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2000	\$			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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 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 Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 10-25-427-035-0000	NURSING HOME	\$ 99,951.66	\$ 99,951.66
2. 10-25-427-010-0000	NURSING HOME	\$ 3,121.98	\$ 3,121.98
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 103,073.64	\$ 103,073.64

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number THE WESTWOOD MANOR

0005249 Report Period Beginning:

01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

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

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	<u>NURSING HOME</u>	<u>33,750</u>	<u>1960</u>	<u>\$ 168,905</u>	1
2					2
3	TOTALS	33,750		\$ 168,905	3

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF 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	\$ 4,870	40	\$ 4,870	\$	\$ 213,771	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		20	298	298	5,633	15
16		FENCING		1982	860		20	43	43	813	16
17		PLUMBING REPAIRS		1983	29,055		20	1,453	1,453	27,480	17
18		BUILDING REPAIR		1983	4,770		20	238	238	4,510	18
19		TILE		1983	1,078		20	54	54	1,021	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	12,859	17	12,820	(39)	166,175	29
30		ELECTRICAL SYSTEM		1990	27,757	1,638	17	1,638		20,903	30
31		VARIOUS IMPROVEMENTS		1990	14,588					14,588	31
32		FURNITURE		1991	76,838					76,838	32
33		REMODELING		1995	31,650	2,265	15	2,110	(155)	13,255	33
34		WINDOWS		1996	3,285	294	10	328	34	1,804	34
35		FIRE AND ALARM SYSTEM		1997	8,608	909	10	861	(48)	3,874	35
36		FLOOR TILE		1997	25,865	3,228	10	2,587	(641)	11,641	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	AIRCONDITIONER	1997	\$ 18,962	\$ 2,367	10	\$ 1,896	\$ (471)	\$ 8,532	37
38	REMODELING ROOMS	1997	6,234	778	10	623	(155)	2,804	38
39	BLACKTOP,TILING BATHROOMS	1998	5,582	1,009	10	558	(451)	1,953	39
40	PARTITIONS	1999	4,225	697	10	422	(275)	1,266	40
41	HVAC SYSTEM REPAIR	2000	13,496	2,227	20	675	(1,552)	1,350	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 984,510	\$ 33,141		\$ 31,474	\$ (1,667)	\$ 819,349	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: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 245,028	\$ 20,042	\$ 24,503	\$ 4,461	10 YR	\$ 174,696	71
72	Current Year Purchases	18,872	2,697	944	(1,753)	10 YR	944	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 263,900	\$ 22,739	\$ 25,447	\$ 2,708		\$ 175,640	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76			1995	\$ 31,890	\$	\$ 6,378	\$ 6,378	5	\$ 31,093	76
77			1997	31,888		6,378	6,378	5	25,510	77
78	FACILITY	1999 CHRYSLER	1999	29,591	2,950	5,918	2,968	5	17,754	78
79	FACILITY	2001 CHRYSLER VAN	2001	36,810	3,060	7,362	4,302	5	7,362	79
80	TOTALS			\$ 130,179	\$ 6,010	\$ 26,036	\$ 20,026		\$ 81,719	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)	\$ 1,547,494	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,890	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,957	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,067	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,076,708	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 Date of Lease	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?

YES NO

16. Rental Amount for movable equipment: \$ 0

Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			N/A		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 Ending	Annual Rent
12.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

* 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.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **THE WESTWOOD MANOR**

0005249

Report Period Beginning: **01/01/2001**

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2001** (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 65,697	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	843,532		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,653		6
7	Other Prepaid Expenses	2,415		7
8	Accounts Receivable (owners or related parties)	16,000		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 962,297	\$ 0	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	740,868		15
16	Equipment, at Historical Cost	393,675		16
17	Accumulated Depreciation (book methods)	(1,010,281)		17
18	Deferred Charges	257		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)	\$ 452,701	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,414,998	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 130,219	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	47,696		29
30	Accrued Salaries Payable	56,928		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,457		31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,381		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	21,017		35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 374,698	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 374,698	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,040,300	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,414,998	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 890,102	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 890,101	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,380,199	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	(1,230,000)	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)	\$ 150,199	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,040,300	24 *

* This must agree with page 17, line 47.

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,719,544	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,719,544	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)	\$ 0	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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)	\$ 0	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,660	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,660	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain (Loss) on Sale Of Assets	(18,058)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (18,058)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,708,146	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	592,631	31
32	Health Care	919,772	32
33	General Administration	578,600	33
B. Capital Expense			
34	Ownership	152,964	34
C. Ancillary Expense			
35	Special Cost Centers	0	35
36	Provider Participation Fee	62,963	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,306,930	40
41	Income before Income Taxes (line 30 minus line 40)**	1,401,216	41
42	Income Taxes	(21,017)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,380,199	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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: 01/01/2001

Ending: 12/31/2001

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	13,864	15,361	362,363	23.59	3
4	Licensed Practical Nurses	2,772	3,100	41,391	13.35	4
5	Nurse Aides & Orderlies	37,600	42,024	360,984	8.59	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,843	3,993	35,257	8.83	10
11	Social Service Workers	7,566	7,982	86,526	10.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,651	14,701	131,722	8.96	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	7,409	7,950	53,739	6.76	18
19	Laundry					19
20	Administrator	2,080	2,091	71,227	34.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,085	111,488	53.47	23
24	Clerical	4,160	4,931	58,828	11.93	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)	95,025	104,218	\$ 1,313,525 *	\$ 12.60	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	M	\$ 5,599	1-3	35
36	Medical Director	O	1,775	9-3	36
37	Medical Records Consultant	N	2,032	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	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	861	10a-3	43
44	Activity Consultant	E	2,256	11-3	44
45	Social Service Consultant	E	6,864	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,387		49

C. CONTRACT NURSES

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

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
CHAYA LIBERMAN	ADMIN	25%	\$ 71,227	Workers' Compensation Insurance	\$ 15,504	IDPH License Fee	\$ 3,357	
JOSEPH LIBERMAN	EXEC DIRECTOR	12.50%	111,488	Unemployment Compensation Insurance	7,318	Advertising: Employee Recruitment	3,357	
				FICA Taxes	98,576	Health Care Worker Background Check	0	
				Employee Health Insurance	88,908	(Indicate # of checks performed)		
				Employee Meals	0	MARKETING/ADV/PROMO	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST FEES/FRANCHISE TX/ETC	100	
				EMPLOYEE BENEFITS - OTHER	0	CONTRIBUTIONS	3,723	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	2,669	
				PENSION/PROFIT SHARING PLANS	0	LICENSES & PERMITS	11,339	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 182,715	CHICAGO HEAD TAX	0	TRUST FEES/CONTRIBUTIONS	(3,823)	
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
B. Administrative - Other						Non-allowable advertising	(0)	
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21	0	Yellow page advertising	(0)	
			\$ 0					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 210,306	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,365	
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	Description	Line #	Amount	Description	Amount
(Attach a copy of any management service agreement)							Out-of-State Travel	\$
C. Professional Services								
Vendor/Payee	Type		Amount				In-State Travel	0
ALPHA DATA	DATA PROCESSING		\$ 2,059					
KRUPNICK, BOKOR	ACCOUNTING FEES		15,200				Seminar Expense	0
PURCHASING PLUS	PURCHASING CONSULT		960					
HAMBLET, OREMUS & LIT.	LEGAL FEES		110				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$
TOTAL (agree to Schedule V, line 19, column 3)			\$ 18,329	TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE WESTWOOD MANOR

Report Period Beginning: 01/01/2001 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY1998	6 FY1999	7 FY2000	8 FY2001	9 FY2002	10 FY2003	11 FY2004	12 FY2005	13 FY2006
1	PAINT/DECORATING	1998	\$ 4,174	3	\$ 696	\$ 1,392	\$ 1,392	\$ 694	\$	\$	\$	\$	\$
2	PAINT/DECORATING	2001	11,755	3				1,959	3,918	3,918	1,960		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 15,929		\$ 696	\$ 1,392	\$ 1,392	\$ 2,653	\$ 3,918	\$ 3,918	\$ 1,960	\$	\$

Facility Name & ID Number THE WESTWOOD MANOR

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$5098
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ 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 of Public Aid during this cost report period. \$ 62,963
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 of Public Aid, 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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,599
	REPAIRS & MAINTENANCE	122
		0
		5,721
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	0
	ELECTRICITY	0
	WATER	0
	CABLE TV - LOBBY	0
	UTILITIES	51,285
		51,285
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,115
	PAINTING & DECORATING	11,755
	BUILDING REPAIRS	99,589
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,830
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,750
	FIRE SERVICE	0
		0
		0
		0
		119,039
7	OTHER	
	SCAVENGER	5,338
	SECURITY SERVICE	2,730
		8,068
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	1,775
		1,775

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	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,032
	PHARMACY CONSULTANT XVIII B 39-2	0
	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
		2,032
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	
	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	861
		861
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,256
		0
		2,256
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	6,864
	SOCIAL WORKER XVIII B 45-2	0
		0
		6,864
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
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	22,605
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	2,059
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	16,270
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	18,329
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	3,357
	CONTRIBUTIONS VI 20 XIX F	250
	DUES & SUBSCRIPTIONS XIX F	2,669
	LICENSES & PERMITS XIX F	11,339
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	100
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,473
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
21	CLERICAL & GENERAL OFFICE EXPENSES	21,188
	BANK CHARGES	0
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	7,401
	MESSENGER SERVICE	0
		0
		7,401

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	98,576
	UNEMPLOYMENT COMPENSATION XIX D	7,318
	WORKERS COMPENSATION INSURANC XIX D	15,504
	HOSPITALIZATION INSURANCE XIX D	88,908
	EMPLOYEE BENEFITS - OTHER XIX D	0
	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
		210,306
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,195
		1,195
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,553
		4,553
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	37,877
		37,877
27	OTHER	
	BAD DEBTS VI 24	0
		0
		0

GRAND TOTAL COLUMN 3 OTHER

521,355

THE WESTWOOD MANOR
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2001

TOTAL FOOD PURCHASE	147,790	PATIENT MEALS	120147
LESS SALES TAX	0	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	147790	TOTAL MEALS/YEAR	120147
TOTAL PATIENT CENSUS	40,049	NET FOOD	147790
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	120147

TOTAL PATIENT MEALS	120147	COST PER MEAL	1.23
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		