		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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: WESTWOOD MANOR THE

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

County: COOK

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

HFS ID Number: 36-2443231

Date of Initial License for Current Owners: 1960

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2008 to 12/31/2008 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)	BOB KAGDA VICE PRESIDENT
	(Firm Name & Address)	KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
	(Telephone)	(847) 675-3585 Fax # (847) 675-5777

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585
Email Address:

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 WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	9,516	1
2		Skilled Pediatric (SNF/PED)			2
3	89	Intermediate (ICF)	89	32,574	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		691		691	8
9	SNF/PED					9
10	ICF	39,023			39,023	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,023	691		39,714	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.35%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1960

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

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	170,941	141,582	23,100	335,623		335,623		335,623			1
2	Food Purchase		205,608		205,608		205,608		205,608			2
3	Housekeeping	58,695	10,660		69,355		69,355		69,355			3
4	Laundry		11,464	493	11,957		11,957		11,957			4
5	Heat and Other Utilities			86,597	86,597		86,597		86,597			5
6	Maintenance		45,384	51,421	96,805		96,805	700	97,505			6
7	Other (specify):*			8,199	8,199		8,199		8,199			7
8	**TOTAL General Services**	229,636	414,698	169,810	814,144		814,144	700	814,844			8
	B. Health Care and Programs											
9	Medical Director			4,300	4,300		4,300		4,300			9
10	Nursing and Medical Records	1,050,555	52,500	8,436	1,111,491		1,111,491		1,111,491			10
10a	Therapy											10a
11	Activities	37,969	10,929	1,980	50,878		50,878		50,878			11
12	Social Services	157,293		10,409	167,702		167,702		167,702			12
13	CNA Training											13
14	Program Transportation			200	200		200		200			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,245,817	63,429	25,325	1,334,571		1,334,571		1,334,571			16
	C. General Administration											
17	Administrative	122,085			122,085		122,085		122,085			17
18	Directors Fees			22,233	22,233		22,233		22,233			18
19	Professional Services			27,922	27,922		27,922		27,922			19
20	Dues, Fees, Subscriptions & Promotions			12,818	12,818		12,818	(5,868)	6,950			20
21	Clerical & General Office Expenses	94,338	10,379	22,467	127,184		127,184	(12,686)	114,498			21
22	Employee Benefits & Payroll Taxes			344,696	344,696		344,696		344,696			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,292	3,292		3,292		3,292			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,615	110,615		110,615		110,615			26
27	Other (specify):*											27
28	**TOTAL General Administration**	216,423	10,379	544,043	770,845		770,845	(18,554)	752,291			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,691,876	488,506	739,178	2,919,560		2,919,560	(17,854)	2,901,706			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#: WESTWOOD MANOR THE **#0005249** **Report Period Beginning: 01/01/2008** **Ending: 12/31/2008**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	21,544	
	REPAIRS & MAINTENANCE		1,556	
			0	23,100
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		493	
			0	493
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		38,968	
	ELECTRICITY		32,997	
	WATER		13,351	
	CABLE TV - LOBBY		1,281	
			0	86,597
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,925	
	PAINTING & DECORATING		1,160	
	BUILDING REPAIRS		34,096	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,234	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,921	
	FIRE SERVICE		85	
			0	
			0	
			0	
			0	51,421
7	**OTHER**			
	SCAVENGER		8,199	
	SECURITY SERVICE		0	
			0	
			0	8,199
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,300	4,300

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	6,596	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,840	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2		
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	8,436
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,980	
			0	1,980
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	10,409	
			0	10,409
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WESTWOOD MANOR THE #0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		200	200
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		22,233	22,233
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,937	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	22,985	
			0	27,922
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,415	
	EMPLOYEE WANT ADS	XIX F	1,720	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	4,384	
	LICENSES & PERMITS	XIX F	846	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,453	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				12,818
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,546	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	12,686	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		6,235	
	MESSENGER SERVICE		0	
			0	22,467

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	128,037	
	UNEMPLOYMENT COMPENSATION	XIX D	8,550	
	WORKERS COMPENSATION INSURANC	XIX D	30,109	
	HOSPITALIZATION INSURANCE	XIX D	176,000	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,000	
	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	344,696
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,292	
	TRAVEL	XIX G	0	
				3,292
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		0	
				0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		110,615	
				110,615
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **739,178**

WESTWOOD MANOR THE
SCHEDULES
12/31/2008

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

TOTAL FOOD PURCHASE	205,608	
LESS SALES TAX	0	**HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??**
NET FOOD	205,608	
TOTAL PATIENT CENSUS	39,714	
TIME 3 MEALS PER DAY	3	
TOTAL PATIENT MEALS	119,142	
ADD # EMPLOYEE MEALS/DAY	0	
TIME # DAYS	366	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	119,142	
ADD EMPLOYEE MEALS	0	
TOTAL MEALS/YEAR	119,142	
NET FOOD	205,608	
DIVIDE TOTAL MEALS/YEAR	119,142	
COST PER MEAL	1.73	
TIME EMPLOYEE MEALS	0	
EMPLOYEE MEAL RECLASSIFICATION	**0**	
	========	

Facility Name & ID Number WESTWOOD MANOR THE #0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			56,543	56,543		56,543	(3,190)	53,353			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			117,651	117,651		117,651	(514)	117,137			32
33	Real Estate Taxes			118,474	118,474		118,474		118,474			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			292,668	292,668		292,668	(3,704)	288,964			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,136	63,136		63,136		63,136			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			63,136	63,136		63,136		63,136			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,691,876	488,506	1,094,982	3,275,364		3,275,364	(21,558)	3,253,806			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 WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,190)	30		9
10	Interest and Other Investment Income	(484)	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	(30)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(12,686)	21		18
19	Entertainment		20		19
20	Contributions	(4,453)	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	(1,415)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	700			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (21,558)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (21,558)		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

WESTWOOD MANOR THE

ID# 0005249

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 700	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
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	700		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	700	0	0	0	0	0	0	0	0	0	0	700	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	700	0	0	0	0	0	0	0	0	0	0	700	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	(5,868)	0	0	0	0	0	0	0	0	0	0	(5,868)	20
21	Clerical & General Office Expenses	(12,686)	0	0	0	0	0	0	0	0	0	0	(12,686)	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**	(18,554)	0	0	0	0	0	0	0	0	0	0	(18,554)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(17,854)	0	0	0	0	0	0	0	0	0	0	(17,854)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,190)	0	0	0	0	0	0	0	0	0	0	(3,190)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(514)	0	0	0	0	0	0	0	0	0	0	(514)	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	(3,704)	0	0	0	0	0	0	0	0	0	0	(3,704)	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)	(21,558)	0	0	0	0	0	0	0	0	0	0	(21,558)	45

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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
SEE ATTACHED SCHEDULE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	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 WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	JOSEPH LIBERMAN	EXECUTIVE DIR.	MANAGING	12.50	0	40	100.00	SALARY	$ 122,085	17-1	1
2	MARLENE NADLER	OUTSIDE DIRECT.	ADMINISTRAT	22.22	0	20	20.00	DIR FEES	11,117	18-3	2
3	ROSALIE EISEMBERGER	OUTSIDE DIRECT.	ADMINISTRAT	22.22	0	20	20.00	DIR FEES	11,116	18-3	3
4	DAVID LIBERMAN	CLERICAL	CLERICAL	0.00	0	40	100.00	SALARY	2,771	21-1	4
5	YAFA LIBERMAN	DIETARY	DIETARY	0.00	0	40	100.00	SALARY	19,500	1-1	5
6	CHAYA LIBERMAN	CLERICAL	CLERICAL	25.00	0	40	100.00	SALARY	35,120	21-1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 201,709		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 WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL	DEMAND	REVOLV	400,000	694,993	REVOLV	PRIME+	113,907	6
7			X	INSURANCE FINANCING							1,731	7
8	CHRYSLER FINANCIAL		X	AUTO LOAN	$774.73	09/05	55,781	25,566	09/11	8.2500	1,983	8
9	TOTAL Facility Related				$774.73		$ 455,781	$ 720,559			$ 117,621	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							30	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 30	14
15	TOTALS (line 9+line14)						$ 455,781	$ 720,559			$ 117,651	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.)

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 2007 report.	$ 120,338	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 118,812	2
3. Under or (over) accrual (line 2 minus line 1).	$ (1,526)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 120,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 118,474	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2003	113,494	8
2004	116,015	9
2005	117,195	10
2006	120,094	11
2007	118,812	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~101% OF PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2007 TAX BILL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 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, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTWOOD MANOR THE 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 2007 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 2007.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-427-035-0000	NURSING HOME	$ 109,854.27	$ 109,854.27
2.	10-25-427-010-0000	NURSING HOME	$ 8,957.74	$ 8,957.74
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 118,812.01	$ 118,812.01

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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOM	33,750	1960	$ 168,905	1
2					2
3	TOTALS	33,750		$ 168,905	3

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	115		1963	1960	$ 210,408	$	40	$	$	$ 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	2,110	15	2,110		27,057	33
34	WINDOWS			1996	3,285		10			3,285	34
35	FIRE AND ALARM SYSTEM			1997	8,608		10			8,608	35
36	FLOOR TILE			1997	25,865		10			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 WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIRCONDITIONER	1997	$ 18,962	$	10	$	$	$ 18,962	37
38	REMODELING ROOMS	1997	6,234		10			6,234	38
39	BLACKTOP,TILING BATHROOMS	1998	5,582		10	281	281	5,582	39
40	PARTITIONS	1999	4,225	253	10	422	169	4,220	40
41	HVAC SYSTEM REPAIR	2000	13,496	749	20	675	(74)	6,075	41
42	FENCE	2002	1,464	86	15	98	12	661	42
43	REMODELING BATHROOMS	2002	8,858	322	27.5	322		2,080	43
44	PARKING LOT PAVING	2004	4,180	836	10	418	(418)	2,090	44
45	DOORS	2004	2,340	117	10	234	117	1,170	45
46	ROOFING	2004	6,000	277	10	600	323	3,000	46
47	KITCHEN REMODELING	2005	86,513	3,146	27.5	3,146		12,453	47
48	ELEVATOR REPAIR	2005	10,500	700	15	700		2,450	48
49	DOORS	2006	1,288	129	10	129		306	49
50	AIRCONDITIONER REPAIRS	2006	3,727	745	5	745		1,769	50
51	FLOORING	2006	130,000	4,727	27.5	4,727		10,439	51
52	NURSES CALL SYSTEM	2006	6,000	1,224	5	1,224		4,164	52
53	BATHROOMS REMODELING	2007	9,000	327	27.5	327		586	53
54	TUCKPOINTING	2007	4,000	145	27.5	145		199	54
55	AWNING	2007	4,845	176	27.5	176		345	55
56	INSTALL NEW SINGLE PLY MODIFIED BUTUMEN ROOF	2008	67,000	1,523	27.5	1,523		1,523	56
57	INSTALL DOMESTIC WATER SYSTEM BOOSTER PUMP	2008	12,000	18	27.5	18		18	57
58	REPAIR HVAC SYSTEM	2008	6,650	1,330	5	1,330		1,330	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)		$ 1,348,875	$ 18,940		$ 19,350	$ 410	$ 980,864	70

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

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	$ 260,895	$ 7,304	$ 23,138	$ 15,834	10	$ 207,490	71
72	Current Year Purchases	41,789	25,074	2,089	(22,985)	10	2,089	72
73	Fully Depreciated Assets	82,969					82,969	73
74								74
75	TOTALS	$ 385,653	$ 32,378	$ 25,227	$ (7,151)		$ 292,548	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	FACILITY	19999 CHRYSLER	1999	$ 29,592	$ 1,775	$	$ (1,775)	5	$ 29,592	76
77	FACILITY	2001 CHRYSLER VAN	2001	36,810	1,775		(1,775)	5	36,810	77
78	FACILITY	2006 CHRYSLER VAN	2005	43,880	1,675	8,776	7,101	5	21,940	78
79										79
80	TOTALS			$ 110,282	$ 5,225	$ 8,776	$ 3,551		$ 88,342	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)	$ 2,013,715	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 56,543	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 53,353	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,190)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,361,754	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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

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

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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		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			N/A				7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			$		$	$		$	14

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

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (35,873)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	608,000		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,576		6
7	Other Prepaid Expenses	7,323		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)**	$ 675,026	$	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	1,164,703		15
16	Equipment, at Historical Cost	517,324		16
17	Accumulated Depreciation (book methods)	(1,334,888)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 675,321	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,350,347	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 206,962	$	26
27	Officer's Accounts Payable	130,062		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	710,559		29
30	Accrued Salaries Payable	20,588		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,479		31
32	Accrued Real Estate Taxes(Sch.IX-B)	120,000		32
33	Accrued Interest Payable	4,483		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)**	$ 1,195,133	$	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)**	$ 1,195,133	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 155,214	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,350,347	$	48

*(See instructions.)

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 60,942	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 60,945	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	894,269	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	(800,000)	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)**	$ 94,269	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)**	$ 155,214	24 *

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

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,180,406	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,180,406	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***	484	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 484	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)**	$ 4,180,890	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	814,144	31
32	Health Care	1,334,571	32
33	General Administration	770,845	33
	B. Capital Expense		
34	Ownership	292,668	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	63,136	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,275,364	40
41	**Income before Income Taxes (line 30 minus line 40)****	905,526	41
42	**Income Taxes**	(11,257)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 894,269	43

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

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

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

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

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	13,408	16,273	493,888	30.35	3
4	Licensed Practical Nurses	2,164	2,448	57,724	23.58	4
5	CNAs & Orderlies	41,066	45,818	498,943	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,557	4,005	37,969	9.48	10
11	Social Service Workers	9,114	10,303	157,293	15.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,400	16,648	170,941	10.27	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	5,794	6,478	58,695	9.06	18
19	Laundry					19
20	Administrator	2,080	2,080	122,085	58.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,342	6,505	94,338	14.50	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)	98,925	110,558	$ 1,691,876 *	$ 15.30	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	$ 21,544	1-3	35
36	Medical Director	O	4,300	9-3	36
37	Medical Records Consultant	N	1,840	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	0	10a-3	43
44	Activity Consultant	E	1,980	11-3	44
45	Social Service Consultant	E	10,409	12-3	45
46	Other(specify)	S		10-3	46
47	PSYCHO-SOCIAL		6,045	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 46,118		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		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOSEPH LIBERMAN	ADMINISTRATOR		$ 122,085
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 122,085

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK, BOKOR,KAGDA	ACCOUNTING	$ 22,025
PURCHASE PLUS	PURCHASING CONSULTANT	960
ALPHA DATA SERVICE	DATA PROCESSING	3,437
LTC SOLUTIONS	DATA PROCESSING	1,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 27,922

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,109
Unemployment Compensation Insurance	8,550
FICA Taxes	128,037
Employee Health Insurance	176,000
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,000
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 344,696

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,720
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	4,453
MARKETING/ADV/PROMO	1,415
LICENSES/DUES/SUBSCRIPTIONS	5,230
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(4,453)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,415)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,950

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	3,292
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,292

**See instructions.

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	PAINT/DECORATING	2005	$ 4,197	3 YRS	$ 699	$ 1,399	$ 1,399	$ 700	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,197		$ 699	$ 1,399	$ 1,399	$ 700	$	$	$	$	$

Facility Name & ID Number WESTWOOD MANOR THE # 0005249 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $8,838**

(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. $ **0** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **63,136**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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