

Facility Name & ID Number THE WESTWOOD MANOR

0005249 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	38,449	661		39,110	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,449	661		39,110	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.17%

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

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 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number **THE WESTWOOD MANOR** # **0005249** Report Period Beginning: **01/01/2010** Ending: **12/31/2010**

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	209,449	137,446	33,616	380,511		380,511		380,511		1
2	Food Purchase		218,547		218,547		218,547		218,547		2
3	Housekeeping	67,328	19,056		86,384		86,384		86,384		3
4	Laundry		6,511	1,993	8,504		8,504		8,504		4
5	Heat and Other Utilities			75,561	75,561		75,561		75,561		5
6	Maintenance		92,714	29,046	121,760		121,760		121,760		6
7	Other (specify):*			24,324	24,324		24,324		24,324		7
8	TOTAL General Services	276,777	474,274	164,540	915,591		915,591		915,591		8
	B. Health Care and Programs										
9	Medical Director			7,700	7,700		7,700		7,700		9
10	Nursing and Medical Records	1,155,516	82,980	19,979	1,258,475		1,258,475		1,258,475		10
10a	Therapy										10a
11	Activities	43,509	12,538	2,548	58,595		58,595		58,595		11
12	Social Services	182,264		27,000	209,264		209,264		209,264		12
13	CNA Training										13
14	Program Transportation			250	250		250		250		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,381,289	95,518	57,477	1,534,284		1,534,284		1,534,284		16
	C. General Administration										
17	Administrative	128,430			128,430		128,430		128,430		17
18	Directors Fees			22,666	22,666		22,666		22,666		18
19	Professional Services			56,346	56,346		56,346		56,346		19
20	Dues, Fees, Subscriptions & Promotions			32,981	32,981		32,981	(4,266)	28,715		20
21	Clerical & General Office Expenses	113,615	12,866	10,452	136,933		136,933		136,933		21
22	Employee Benefits & Payroll Taxes			359,924	359,924		359,924		359,924		22
23	Inservice Training & Education			1,750	1,750		1,750		1,750		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,019	1,019		1,019		1,019		25
26	Insurance-Prop.Liab.Malpractice			72,381	72,381		72,381		72,381		26
27	Other (specify):*										27
28	TOTAL General Administration	242,045	12,866	557,519	812,430		812,430	(4,266)	808,164		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,900,111	582,658	779,536	3,262,305		3,262,305	(4,266)	3,258,039		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	30,840
	REPAIRS & MAINTENANCE	2,776
		0
		33,616
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,993
		0
		1,993
5	HEAT & OTHER UTILITIES	
	GAS HEAT	25,623
	ELECTRICITY	30,427
	WATER	18,104
	CABLE TV - LOBBY	1,407
		0
		75,561
6	MAINTENANCE	
	GROUNDS MAINTENANCE	10,516
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	5,498
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,175
	FIRE SERVICE	8,857
		0
		0
		0
		0
		29,046
7	OTHER	
	SCAVENGER	14,799
	SECURITY SERVICE	9,525
		0
		0
		24,324
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	7,700
		7,700

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	395
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	13,205
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,248
	PHARMACY CONSULTANT XVIII B 39-2	600
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	3,531
		0
		0
		19,979
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	2,548
		0
		2,548
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	27,000
		0
		27,000
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	250
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	22,666
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,576
	ADMINISTRATIVE CONSULTANTS XIX C	4,210
	PROFESSIONAL FEES XIX C	39,560
		0
		56,346
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	17,341
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,894
	LICENSES & PERMITS XIX F	4,200
	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	4,266
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,000
	PATIENT BACKGROUND CHECKS XIX F	280
		32,981
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,136
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	6,316
	MESSENGER SERVICE	0
		0
		10,452

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	144,009
	UNEMPLOYMENT COMPENSATION XIX D	10,281
	WORKERS COMPENSATION INSURANC XIX D	24,661
	HOSPITALIZATION INSURANCE XIX D	178,693
	EMPLOYEE BENEFITS - OTHER XIX D	2,280
	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
		359,924
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,750
		1,750
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,019
		1,019
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	72,381
		72,381
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

779,536

**THE WESTWOOD MANOR
SCHEDULES
12/31/2010**

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

TOTAL FOOD PURCHASE	218,547
LESS SALES TAX	<u>0</u>
NET FOOD	218,547

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

TOTAL PATIENT CENSUS	39,110
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	117,330

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	117,330
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	117,330

NET FOOD	218,547
DIVIDE TOTAL MEALS/YEAR	<u>117,330</u>

COST PER MEAL	1.86
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			66,646	66,646		66,646	(21,913)	44,733			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,095	46,095		46,095	(398)	45,697			32
33	Real Estate Taxes			75,932	75,932		75,932		75,932			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,294	3,294		3,294		3,294			35
36	Other (specify):*											36
37	TOTAL Ownership			191,967	191,967		191,967	(22,311)	169,656			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			62,963	62,963		62,963		62,963			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			62,963	62,963		62,963		62,963			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,900,111	582,658	1,034,466	3,517,235		3,517,235	(26,577)	3,490,658			45

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

THE WESTWOOD MANOR

ID# 0005249

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	DEFERRED MAINTENANCE	\$	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		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE WESTWOOD MANOR# 0005249

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,266)	0	0	0	0	0	0	0	0	0	0	(4,266)	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	(4,266)	0	0	0	0	0	0	0	0	0	0	(4,266)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,266)	0	0	0	0	0	0	0	0	0	0	(4,266)	29

STATE OF ILLINOIS

Facility Name & ID Number THE WESTWOOD MANOR# 0005249

Report Period Beginning:

01/01/2010 Ending:

Summary B

12/31/2010

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(21,913)	0	0	0	0	0	0	0	0	0	0	(21,913)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(398)	0	0	0	0	0	0	0	0	0	0	(398)	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	(22,311)	0	0	0	0	0	0	0	0	0	0	(22,311)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(26,577)	0	0	0	0	0	0	0	0	0	0	(26,577)	45

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 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:

01/01/2010

Ending:

12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JOSEPH LIBERMAN	EXECUTIVE DIR.	MANAGING	12.50	0	40		SALARY	\$ 128,430	17-1	1
2	MARLENE NADLER	OUTSIDE DIRECT.	ADMINISTRAT	22.22	0	20		DIR FEES	11,333	18-3	2
3	ROSALIE EISEMBERGER	OUTSIDE DIRECT.	ADMINISTRAT	22.22	0	20		DIR FEES	11,333	18-3	3
4	Yafa LIBERMAN	DIETARY	DIETARY	0.00	0	40		SALARY	19,500	1-1	4
5	CHAYA LIBERMAN	CLERICAL	CLERICAL	25.00	0	40		SALARY	35,460	21-1	5
6	MARLENE NADLER	ADM CONSULTANT	CONSULT	22.22	0	20		ADM CONS	4,210	19-3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 210,266		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:

01/01/2010

Ending: 2/31/2010

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

THE WESTWOOD MANOR

0005249

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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										
										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	464,030	REVOLV	PRIME+	42,633	6								
7	IMPERIAL CREDIT CORP	X	INSURANCE FINANCING							1,479	7								
8	CHRYSLER FINANCIAL	X	AUTO LOAN	\$774.73	09/05	55,781	6,973	09/11	8.2500	1,983	8								
9	TOTAL Facility Related			\$774.73		\$ 455,781	\$ 471,003			\$ 46,095	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 455,781	\$ 471,003			\$ 46,095	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

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

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

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 2009 report.		\$	121,204	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.)		\$	102,790	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(18,414)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	103,818	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 \$ <u>9,472</u> For <u>2007</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(9,472)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	75,932	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	<u>116,015</u>	8	
	2006	<u>117,195</u>	9	
	2007	<u>120,094</u>	10	
	2008	<u>120,004</u>	11	
	2009	<u>102,790</u>	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.				
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE WESTWOOD MANOR COUNTY _____

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 2009 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 2009.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>10-25-427-035-0000</u>	<u>NURSING HOME</u>	\$ <u>98,319.82</u>	\$ <u>98,319.82</u>
2.	<u>10-25-427-010-0000</u>	<u>NURSING HOME</u>	\$ <u>4,470.47</u>	\$ <u>4,470.47</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>102,790.29</u></u>	\$ <u><u>102,790.29</u></u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 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>	<u>1</u>
2					<u>2</u>
3	TOTALS	33,750		\$ 168,905	3

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	115		1963	1960	\$ 210,408	\$		\$		\$ 210,408	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		FULLY DEPRECIATED		1970	152,196					115,986	9
10		BUILDING REPAIR		1971	1,475					1,475	10
11		BUILDING REPAIR		1976	2,800					2,800	11
12		HEATING REPAIR		1980	4,222					4,222	12
13		ALARM		1980	3,500					3,500	13
14		ROOF		1981	13,500					13,500	14
15		PLUMBING REPAIRS		1982	5,956					5,956	15
16		FENCING		1982	860					860	16
17		PLUMBING REPAIRS		1983	29,055					29,055	17
18		BUILDING REPAIR		1983	4,770					4,770	18
19		TILE		1983	1,078					1,078	19
20		FURNITURE		1985	8,676					8,676	20
21		BUILDING IMPROVEMENTS		1986	3,533					3,533	21
22		WINDOW DRAPES		1986	15,402					15,402	22
23		TUCKPOINTING		1986	670					670	23
24		FURNITURE		1987	5,156					5,156	24
25		FURNITURE & IMPROVEMENTS		1988	2,183					2,183	25
26		ROOF		1988	30,900					30,900	26
27		PARKING LOT		1989	30,485					30,485	27
28		BUILDING IMPROVEMENTS		1990	2,650					2,650	28
29		HEATING IMPROVEMENTS		1990	217,945					217,945	29
30		ELECTRICAL SYSTEM		1990	27,757					27,757	30
31		VARIOUS IMPROVEMENTS		1990	14,588					14,588	31
32		FURNITURE		1991	76,838					76,838	32
33		REMODELING		1995	31,650	71	15	71		29,238	33
34		WINDOWS		1996	3,285					3,285	34
35		FIRE AND ALARM SYSTEM		1997	8,608					8,608	35
36		FLOOR TILE		1997						25,865	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning:

01/01/2010 Ending: 12/31/2010

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	\$		\$	\$	\$ 18,962	37
38	REMODELING ROOMS	1997	6,234					6,234	38
39	BLACKTOP,TILING BATHROOMS	1998	5,582					5,582	39
40	PARTITIONS	1999	4,225					4,225	40
41	HVAC SYSTEM REPAIR	2000	13,496	655	20	655		7,405	41
42	FENCE	2002	1,464	87	15	87		846	42
43	REMODELING BATHROOMS	2002	8,858	322	27.5	322		2,724	43
44	PARKING LOT PAVING	2004	4,180		10	418	418	2,926	44
45	DOORS	2004	2,340	117	10	234	117	1,638	45
46	ROOFING	2004	6,000	197	10	600	403	4,200	46
47	KITCHEN REMODELING	2005	86,513	3,146	27.5	3,146		18,745	47
48	ELEVATOR REPAIR	2005	10,500	700	15	700		3,850	48
49	DOORS	2006	1,288	129	10	129		564	49
50	AIRCONDITIONER REPAIRS	2006	3,727	745	5	745		3,259	50
51	FLOORING	2006	130,000	4,727	27.5	4,727		19,893	51
52	NURSES CALL SYSTEM	2006	6,000	678	5	678		5,576	52
53	BATHROOMS REMODELING	2007	9,000	327	27.5	327		1,240	53
54	TUCKPOINTING	2007	4,000	145	27.5	145		489	54
55	AWNING	2007	4,845	176	27.5	176		697	55
56	INSTALL NEW SINGLE PLY MODIFIED BUTUMEN ROOF	2008	67,000	2,436	27.5	2,436		6,395	56
57	INSTALL DOMESTIC WATER SYSTEM BOOSTER PUMP	2008	12,000	436	27.5	436		890	57
58	REPAIR HVAC SYSTEM	2008	6,650	1,277	5	1,277		4,735	58
59	INSTALLED NEW FAN MOTOR & CYCLING CONTROL	2009	5,397	196	27.5	196		286	59
60	INSTALLED 2 NEW BOILERS	2009	41,950	1,525	27.5	1,525		1,589	60
61	CUBICAL CURTAIN	2009	3,253	520	5	520		2,472	61
62	INSTALLATION OF FIRE ALARM SYSTEM DEVICES	2010	17,959	517	27.5	517		517	62
63	REMODEL BATHROOM #111 WITH NEW TILE FLOOR	2010	4,550	103	27.5	103		103	63
64	INSTALL 28 COUNTER TOPS	2010	5,323	57	27.5	57		57	64
65	PAINTING OF CABINETS	2010	21,661	4,332	5	4,332		4,332	65
66	NEW GRRENHOUSE-INSTALLATION OF FOUNDATION,	2010	46,805	496	27.5	496		496	66
67	LEVELING BASE WALL & TUBULAR FRAMING, SOLAR								67
68	SHEETING ON EXTERIOR, REPAIR AND SEALING FLOOR,								68
69	INSTALLING ROUGH ELECTRIC AND LIGHTING								69
70	TOTAL (lines 4 thru 69)		\$ 1,469,908	\$ 24,117		\$ 25,055	\$ 938	\$ 1,028,316	70

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

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	\$ 160,576	\$ 9,113	\$ 10,099	\$ 986	10	\$ 79,735	71
72	Current Year Purchases	49,552	31,741	2,478	(29,263)	10	2,478	72
73	Fully Depreciated Assets	242,428					242,428	73
74								74
75	TOTALS	\$ 452,556	\$ 40,854	\$ 12,577	\$ (28,277)		\$ 324,641	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	2006 CHRYSLER VAN	2005	\$ 43,880	\$ 1,675	\$ 7,101	\$ 5,426	5	\$ 37,817	76
77										77
78										78
79										79
80	TOTALS			\$ 43,880	\$ 1,675	\$ 7,101	\$ 5,426		\$ 37,817	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)	\$ 2,135,249	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,646	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,733	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (21,913)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,390,774	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 3,294 Description: COPIER MACHINE

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

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

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

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

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits			N/A				6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts							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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2010**

(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	\$ 258,605	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	64,044		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,198		6
7	Other Prepaid Expenses	7,784		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 400,631	\$	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	1,311,601		15
16	Equipment, at Historical Cost	517,825		16
17	Accumulated Depreciation (book methods)	(1,403,435)		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): Construction-in-Progress	27,096		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 781,269	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,181,900	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 147,249	\$	26
27	Officer's Accounts Payable	94,067		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	538,525		29
30	Accrued Salaries Payable	78,241		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,906		31
32	Accrued Real Estate Taxes(Sch.IX-B)	103,818		32
33	Accrued Interest Payable	2,898		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)	\$ 972,704	\$	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)	\$ 972,704	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 209,196	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,181,900	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 81,802	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 81,804	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	935,392	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	(808,000)	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)	\$ 127,392	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)	\$ 209,196	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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	\$ 4,465,286	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,465,286	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***	398	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 398	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)	\$ 4,465,684	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	915,591	31
32	Health Care	1,534,284	32
33	General Administration	812,430	33
B. Capital Expense			
34	Ownership	191,967	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	62,963	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,517,235	40
41	Income before Income Taxes (line 30 minus line 40)**	948,449	41
42	Income Taxes	(13,057)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 935,392	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 **THE WESTWOOD MANOR**

0005249

Report Period Beginning: **01/01/2010**

Ending:

12/31/2010

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	13,529	15,455	489,888	31.70	3
4	Licensed Practical Nurses	4,475	4,978	125,595	25.23	4
5	CNAs & Orderlies	42,175	45,874	540,033	11.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,307	4,470	43,509	9.73	10
11	Social Service Workers	10,145	11,078	182,264	16.45	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	19,500	9.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,292	17,088	189,949	11.12	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	5,932	6,663	67,328	10.10	18
19	Laundry					19
20	Administrator	2,080	2,080	128,430	61.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,826	7,915	113,615	14.35	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)	107,841	117,681	\$ 1,900,111 *	\$ 16.15	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	512	\$ 30,840	1-3	35
36	Medical Director	Monthly	7,700	9-3	36
37	Medical Records Consultant	Monthly	2,248	10-3	37
38	Nurse Consultant	Monthly	3,531	10-3	38
39	Pharmacist Consultant	Monthly	600	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	52	2,548	11-3	44
45	Social Service Consultant	1,571	27,000	12-3	45
46	Other(specify)				46
47	Psycho-Social	Monthly	13,205	10-3	47
48					48
49	TOTAL (lines 35 - 48)	2,135	\$ 87,672		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	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JOSEPH LIBERMAN	ADMINISTRATOR	12.5	\$ 128,430	Workers' Compensation Insurance	\$ 24,661	IDPH License Fee	\$ 4,050	
				Unemployment Compensation Insurance	10,281	Advertising: Employee Recruitment	17,341	
				FICA Taxes	144,009	Health Care Worker Background Check	1,000	
				Employee Health Insurance	178,693	(Indicate # of checks performed 100)		
				Employee Meals	0	Patient Background Checks	7 280	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,266	
				EMPLOYEE BENEFITS - OTHER	2,280	MARKETING/ADV/PROMO	0	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	6,044	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(4,266)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(0)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 128,430	TOTAL (agree to Schedule V, line 22, col.8)	\$ 359,924	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,715	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							Seminar Expense	
								0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$
C. Professional Services								
Vendor/Payee	Type		Amount					
ALPHA DATA SERVICE	DATA PROCESSING		\$ 3,536					
LTC SOLUTIONS	DATA PROCESSING		1,800					
PURCHASING PLUS	PURCHASING CONSULTANT		870					
KRUPNICK, BOKOR, KAGDA	ACCOUNTING		18,350					
E-HEALTH DATA SOLUTIONS	DATA PROCESSING		7,240					
ASHMAN & STEIN	LEGAL FFES		2,275					
ELLIOT M. SAMUELS	LEGAL FFES		3,520					
MARVI F. POER & COMPANY	STATE & LOCAL TAX CONS		11,745					
MCCORMICK & WAGNER	PROPERTY TAX ADVISOR		2,800					
MARLENE NADLER	ADM. CONSULTANT		4,210					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 56,346					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 \$5,894
- (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. \$ 12,192 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. \$ 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, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.