

Facility Name & ID Number THE WESTWOOD MANOR

0005249 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	89	Intermediate (ICF)	89	32,485	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			725	725	8
9	SNF/PED					9
10	ICF	35,601	513		36,114	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,601	513	725	36,839	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.76%

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 26 and days of care provided 725

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	207,403	105,133	28,222	340,758		340,758		340,758		1
2	Food Purchase		261,211		261,211		261,211		261,211		2
3	Housekeeping	97,912	55,352		153,264		153,264		153,264		3
4	Laundry		10,640	1,284	11,924		11,924		11,924		4
5	Heat and Other Utilities			81,556	81,556		81,556		81,556		5
6	Maintenance		40,840	14,887	55,727		55,727		55,727		6
7	Other (specify):*			14,535	14,535		14,535		14,535		7
8	TOTAL General Services	305,315	473,176	140,484	918,975		918,975		918,975		8
	B. Health Care and Programs										
9	Medical Director			14,200	14,200		14,200		14,200		9
10	Nursing and Medical Records	1,190,993	83,571	20,164	1,294,728		1,294,728		1,294,728		10
10a	Therapy										10a
11	Activities	58,400	20,371	2,400	81,171		81,171		81,171		11
12	Social Services	102,340			102,340		102,340		102,340		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,351,733	103,942	36,764	1,492,439		1,492,439		1,492,439		16
	C. General Administration										
17	Administrative	261,557			261,557		261,557		261,557		17
18	Directors Fees			45,208	45,208		45,208		45,208		18
19	Professional Services			84,915	84,915		84,915		84,915		19
20	Dues, Fees, Subscriptions & Promotions			35,252	35,252		35,252	(671)	34,581		20
21	Clerical & General Office Expenses	58,954	14,075	26,117	99,146		99,146	(1,707)	97,439		21
22	Employee Benefits & Payroll Taxes			370,046	370,046		370,046		370,046		22
23	Inservice Training & Education			2,565	2,565		2,565		2,565		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			4,143	4,143		4,143		4,143		25
26	Insurance-Prop.Liab.Malpractice			82,608	82,608		82,608		82,608		26
27	Other (specify):*										27
28	TOTAL General Administration	320,511	14,075	650,854	985,440		985,440	(2,378)	983,062		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,977,559	591,193	828,102	3,396,854		3,396,854	(2,378)	3,394,476		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	21,671
	REPAIRS & MAINTENANCE	6,551
		28,222
3	HOUSEKEEPING	
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,284
		1,284
5	HEAT & OTHER UTILITIES	
	GAS HEAT	19,098
	ELECTRICITY	36,258
	WATER	22,915
	CABLE TV - LOBBY	3,285
		81,556
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,710
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,297
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,225
	FIRE SERVICE	3,655
		14,887
7	OTHER	
	SCAVENGER	14,535
	SECURITY SERVICE	0

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	6,294
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,030
	PHARMACY CONSULTANT XVIII B 39-2	9,840
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		20,164
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,400
		2,400
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0

			14,535
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	14,200

			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
		0
	DIRECTORS FEES	
18	DIRECTORS FEES	45,208
		45,208
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	38,911
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	38,564
	SETTLEMENT-LEGAL	7,440
		84,915
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	28,391
	CONTRIBUTIONS VI 20 XIX F	360
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	2,770
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	311
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,920
	PATIENT BACKGROUND CHECKS XIX F	1,500
		35,252
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,087
	EQUIPMENT REPAIR & MAINTENANCE	8,758
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	1,707
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	10,565

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	150,356
	UNEMPLOYMENT COMPENSATION XIX D	42,504
	WORKERS COMPENSATION INSURANC XIX D	47,832
	HOSPITALIZATION INSURANCE XIX D	126,593
	EMPLOYEE BENEFITS - OTHER XIX D	2,761
	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
		370,046
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,565
		2,565
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,143
		4,143
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	82,608
		82,608
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER **828,102**

MESSENGER SERVICE	0	
		26,117

**THE WESTWOOD MANOR
SCHEDULES
12/31/2015**

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

TOTAL FOOD PURCHASE	261,211	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	261,211	
TOTAL PATIENT CENSUS	36,839	
TIMES 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	110,517	
ADD # EMPLOYEE MEALS/DAY		
TIMES # DAYS	<u>365</u>	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	110,517	
ADD EMPLOYEE MEALS	<u>0</u>	
TOTAL MEALS/YEAR	110,517	
NET FOOD	261,211	
DIVIDE TOTAL MEALS/YEAR	<u>110,517</u>	
COST PER MEAL	2.36	
TIMES EMPLOYEE MEALS	<u>0</u>	
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>	

**THE WESTWOOD MANOR
PROFESSIONAL FEES SCHEDULES
12/31/2015**

<u>VENDER/PAYEE</u>	<u>DESCRIPTION</u>	<u>AMOUNT</u>
ALPHA DATA SERVICES, LLC	DATA PROCESSING	4,072
WESCOM SOLUTIONS	DATA PROCESSING	29,141
ABILITY NETWORK	DATA PROCESSING	3,529
NATIONAL DATACARE	DATA PROCESSING	1,387
EMDEON	DATA PROCESSING	782
KBKB, LTD	ACCOUNTING FEES	21,500
PURCHASING PLUS	PURCHASE CONSULTANT	960
RICHARD PEELO & ASSOCIATES	MEDICARE CONSULTANT	3,300
MEDICARE CONSULTANT	MEDICARE CONSULTANT	1,240
MARVIN POER AND COMPANY	PROPERTY TAX ADVISOR	8,319
MCCORMICK & WAGNER, LLC	REAL ESTATE APPRAISERS	2,800
INTERIOR CONSULTANT	INTERIOR DECORATING CONSULTANT	325
RELIGEN CONSULTANT	RELIGEN CONSULTANT	120
RESIDENT	SETTLEMENT	7,440
TOTAL		<u><u>84,915</u></u>

Facility Name & ID Number THE WESTWOOD MANOR

#0005249

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			56,600	56,600		56,600	17,394	73,994			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,984	53,984		53,984		53,984			32
33	Real Estate Taxes			134,054	134,054		134,054		134,054			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,673	3,673		3,673		3,673			35
36	Other (specify):*											36
37	TOTAL Ownership			248,311	248,311		248,311	17,394	265,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,132	82,925	106,057		106,057		106,057			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			282,791	282,791		282,791		282,791			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		23,132	365,716	388,848		388,848		388,848			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,977,559	614,325	1,442,129	4,034,013		4,034,013	15,016	4,049,029			45

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

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

0005249

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	17,394	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(311)	20		17
18	Fines and Penalties	(1,707)	21		18
19	Entertainment		20		19
20	Contributions	(360)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 15,016		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 15,016		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

THE WESTWOOD MANOR

ID# 0005249

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
1				1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29

30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE WESTWOOD MANOR# 0005249

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(671)	0	0	0	0	0	0	0	0	0	0	(671)	20
21	Clerical & General Office Expenses	(1,707)	0	0	0	0	0	0	0	0	0	0	(1,707)	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	(2,378)	0	0	0	0	0	0	0	0	0	0	(2,378)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,378)	0	0	0	0	0	0	0	0	0	0	(2,378)	29

STATE OF ILLINOIS

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning:

01/01/2015 Ending:

Summary B

12/31/2015

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	17,394	0	0	0	0	0	0	0	0	0	0	17,394	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	17,394	0	0	0	0	0	0	0	0	0	0	17,394	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)	15,016	0	0	0	0	0	0	0	0	0	0	15,016	45

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6 - SUPPLEMENTAL						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES 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: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	JOSEPH LIBERMAN	25.00						2
3	BETTY EBERT TRUST	25.00						3
4	MARLENE NADLER	25.00						4
5	ROSALIE EISENBERGER	22.20						5
6	ROSALIE EISENBERGER CUST. FOR							6
7	SHLOMO M. EISENBERGER	1.40						7
8	ROSALIE EISENBERGER CUST. FOR							8
9	YOSEF Z. EISENBERGER	1.40						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

Facility Name & ID Number THE WESTWOOD MANOR # 0005249 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	25.00		40	80.00	SALARY	\$ 128,079	17-1	1
2	JOSEPH LIBERMAN	OUTSIDE DIRECT.	ADMINISTRAT			10	20.00	DIR FEES	11,302	18-3	2
3	BETTY EBERT TRUST	OUTSIDE DIRECT.	ADMINISTRAT	25.00		10	25.00	DIR FEES	11,302	18-3	3
4	MARLENE NADLER	OUTSIDE DIRECT.	ADMINISTRAT	25.00		10	25.00	DIR FEES	11,302	18-3	4
5	ROSALIE EISEMBERGER	OUTSIDE DIRECT.	ADMINISTRAT	22.20		10	25.00	DIR FEES	11,302	18-3	5
6	Yafa LIBERMAN	DIETARY	DIETARY			40	100.00	SALARY	19,500	1-1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 192,787		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: 01/01/2015

Ending: 2/31/2015

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: 01/01/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	MB FINANCIAL	X		WORKING CAPITAL	\$4,444.44	10/15/11	\$ 800,000	\$ 586,667	10/15/16	4.5000	\$ 28,087	1								
2												2								
3	MB FINANCIAL	X		WORKING CAPITAL	\$8,046.56	06/05/13	873,133	418,564	06/05/18	5.2500	23,873	3								
4												4								
5												5								
Working Capital																				
6	MB FINANCIAL	X		WORKING CAPITAL	DEMAND	REVOLV	800,000			PRIME+	306	6								
7												7								
8	FIRST INSURANCE	X		INSURANCE FINANCING							1,718	8								
9	TOTAL Facility Related				\$12,491.00		\$ 2,473,133	\$ 1,005,231			\$ 53,984	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 2,473,133	\$ 1,005,231			\$ 53,984	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

1. Real Estate Tax accrual used on 2014 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	133,740	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.)			\$	135,054	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,314	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	136,404	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>3,664</u> For <u>###</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(3,664)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	134,054	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>112,046</u>	8	FOR BHF USE ONLY	
	2011	<u>111,580</u>	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012	<u>130,619</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	<u>132,387</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2014	<u>135,054</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
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 2014 TAX BILL.					

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.

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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:

01/01/2015 Ending:

12/31/2015

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>33,750</u>	<u>1960</u>	<u>\$ 168,905</u>	1
2					2
3	TOTALS	33,750		\$ 168,905	3

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning:

01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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					31,650	33
34		WINDOWS		1996	3,285					3,285	34
35		FIRE AND ALARM SYSTEM		1997	8,608					8,608	35
36		FLOOR TILE		1997	25,865					25,865	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number THE WESTWOOD MANOR

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Ending:

12/31/2015

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

1	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		20	655	655	10,680	41
42	FENCE	2002	1,464	86	15	86		1,278	42
43	REMODELING BATHROOMS	2002	8,858	322	27.5	322		4,334	43
44	PARKING LOT PAVING	2004	4,180		10			4,180	44
45	DOORS	2004	2,340		10			2,340	45
46	ROOFING	2004	6,000		10			6,000	46
47	KITCHEN REMODELING	2005	86,513	3,146	27.5	3,146		34,475	47
48	ELEVATOR REPAIR	2005	10,500	700	15	700		7,350	48
49	DOORS	2006	1,288	129	10	129		1,209	49
50	AIRCONDITIONER REPAIRS	2006	3,727		5			3,727	50
51	FLOORING	2006	130,000	4,727	27.5	4,727		43,528	51
52	NURSES CALL SYSTEM	2006	6,000		5			6,000	52
53	BATHROOMS REMODELING	2007	9,000	327	27.5	327		2,875	53
54	TUCKPOINTING	2007	4,000	145	27.5	145		1,214	54
55	AWNING	2007	4,845	176	27.5	176		1,577	55
56	INSTALL NEW SINGLE PLY MODIFIED BUTUMEN ROOF	2008	67,000	2,436	27.5	2,436		18,575	56
57	INSTALL DOMESTIC WATER SYSTEM BOOSTER PUMP	2008	12,000	436	27.5	436		3,070	57
58	REPAIR HVAC SYSTEM	2008	6,650		5			6,650	58
59	INSTALLED NEW FAN MOTOR & CYCLING CONTROL	2009	5,397	196	27.5	196		1,266	59
60	INSTALLED 2 NEW BOILERS	2009	41,950	1,525	27.5	1,525		9,214	60
61	CUBICAL CURTAIN	2009	3,253		5			3,253	61
62	INSTALLATION OF FIRE ALARM SYSTEM DEVICES	2010	17,959	653	27.5	653		3,782	62
63	REMODEL BATHROOM #111 WITH NEW TILE FLOOR	2010	4,550	165	27.5	165		928	63
64	INSTALL 28 COUNTER TOPS	2010	5,323	194	27.5	194		1,027	64
65	PAINTING OF CABINETS	2010	21,661	1,248	5	1,248		21,661	65
66	NEW GRRENHOUSE-INSTALLATION OF FOUNDATION,	2010	46,805	1,702	27.5	1,702		9,006	66
67	LEVELING BASE WALL & TUBULAR FRAMING, SOLAR								67
68	SHEETING ON EXTERIOR, REPAIR AND SEALING FLOOR,								68
69	INSTALLING ROUGH ELECTRIC AND LIGHTING								69
70	TOTAL (lines 4 thru 69)		\$ 1,495,773	\$ 18,313		\$ 18,968	\$ 655	\$ 1,144,003	70

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

Facility Name & ID Number THE WESTWOOD MANOR

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,495,773	\$ 18,313		\$ 18,968	\$ 655	\$ 1,144,003	1
2	INSTALL NEW THERMOSTAT, CHAHGE OVER SWITCHES	2010	27,096	985	27.5	985		4,884	2
3	INSTALL NEW MIXING VALVES IN TUB & SHOWER ROOM	2011	11,113	404	27.5	404		2,003	3
4	BUILD NEW STORAGE SHED INCLUDES FIBERGLASS,								4
5	SHINGLES AND VINYL SIDING WITH TWO DOORS	2011	9,370	341	27.5	341		1,577	5
6	REMODEL RECEPTION AREA: INSTALL DROPPED CELLING,								6
7	LIGHTS, FAN,COUNTER TOPS,CHAIR RAIL,NEW SHELIVING								7
8	UNIT, SWITCHES AND OUTLETS, PAINTING WALLS	2011	14,864	541	27.5	541		2,502	8
9	COURT YARD: INSTALL ASPHALT SURFACE; PATCH								9
10	MAIN PARKING LOT AREA:INSTALL BITUMINOUS								10
11	SURFACE, ROLL AND COMPACT,GRIND BUTT JOINTS;								11
12	SEALCOAT ASPHALT PAVEMEN	2011	12,405	827	15	827		3,722	12
13	INSTALL NEW PUMP CONTOLLER	2011	4,600	167	27.5	167		731	13
14	BUILD NEW CONCRETE SIDEWALK, INSTALL METAL POS	2011	5,588	373	15	373		1,554	14
15	ADDITION OF SPRINKLER HEADS IN SKY LIGHTS	2011	2,520	92	27.5	92		380	15
16	RELOCATION OF WIRES TO PREVENT FLOOD DAMAGE	2011	5,000	182	27.5	182		751	16
17	BATHROOM-DEMO SHOWER WALLS AND FLOOR	2012	6,405	233	27.5	233		845	17
18	FURNISH & INSTALL NEW 2 TON AIR CONDITION UNIT	2012	7,000	255	27.5	255		946	18
19	LIGHTING RETROFIT TO INCREASE THE ENERGY EFFICI	2012	14,242	518	27.5	518		1,835	19
20	WINDOW TREATMENTS INSTALLATION	2012	3,570	411	5	411		2,952	20
21	SEALCOATING OF THE PARKING LOT	2012	2,945	196	15	196		653	21
22	INSTALL ADDITIONAL SUBPANEL(RESIDENTIAL GRADE)	2012	4,250	155	27.5	155		497	22
23	KITCHEN POT AND PAN AREA: DEMO DRYWALL,ROD	2012	10,921	397	27.5	397		1,241	23
24	DRAINS, DEMO FIRING STRIPS,DEMO MARLITE WALL								24
25	WIRING CIRCUITS FOR SIX ROOMS; INSTALLING NEW	2012	3,200	116	27.5	116		353	25
26	RECEPTACLES AND PLATES								26
27	FURNISH & INSTALL HOLLOW METAL PEDESTRIAN DOOR								27
28	AND FRAME	2013	8,700	316	27.5	316		935	28
29	CURTAINS RECOVERED AND COMPLETE AND INSTALLED	2013	3,170	115	27.5	115		283	29
30	INSTALLING OUTDOOR FIXTURES AND RECEPTACLES IN								30
31	RECORDS & MEETING ROOM; NEW EXIT SIGNS	2013	4,100	273	15	273		660	31
32	FIRE ALARM SYSTEM DEVICES: REPLACED TAMPER PANEL								32
33	AND ANNUNCIATOR	2013	2,832	103	27.5	103		236	33
34	TOTAL (lines 1 thru 33)		\$ 1,659,664	\$ 25,313		\$ 25,968	\$ 655	\$ 1,173,543	34

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

Facility Name & ID Number THE WESTWOOD MANOR

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,659,664	\$ 25,313		\$ 25,968	\$ 655	\$ 1,173,543	1
2	GARDEN BEDS FOR RESIDENTS:BUILDING OF 4 RAISED								2
3	BED GARDEN & ONE WHEELCHAIR ACCESSIBLE BED	2013	13,220	881	15	881		1,835	3
4	REMODELING : REPLACEMENT FAN COIL UNITS, INSTALLED								4
5	NEW FLUSH MOUNT FAN COIL UNITS IN CENTER OF.								5
6	DINING ROOM, NEW HOT WATER CHILLED WATER PIPING,								6
7	NEW CONDENSATE DRAIN PUMPS FOR FAN COIL UNITS,								7
8	NEW ROOF CURBS, NEW SUPPLY DUCTING, DIFFUSERS,								8
9	REWORKED SPRINKLER SYSTEM IN FIVE BATHROOM	2013	92,565	3,366	27.5	3,366		6,872	9
10	FRONT ENTRANCE, DINING ROOM,ALL HALLWAYS,								10
11	CONFERENCE ROOM, THERAPY ROOM, RESIDENT ROOMS								11
12	& BATHROOMS:INSTALL NEW FRAMING, DRYWALL,								12
13	CHAIR MOLDING, PANELING AND VANIL BASE, PAINTING								13
14	CEILING AND WALLS, DOOR AND WALL CORNERS	2013	238,015	8,655	27.5	8,655		17,671	14
15	BATHROOM (SMALL) AND BATHROOM WITH SHOWER:								15
16	INSTALL NEW CEILING DRYWALL, FLOOR AND WALL TILE,								16
17	NEW WATER LINE, PAINTING, DOOR CASING	2015	20,356	648	27.5	648		648	17
18	INSTALL CUBICLE CURTAIN	2015	2,714	543	5	543		543	18
19	MEN'S BATHROOM: INSTALLATION NEW FRAMING,								19
20	DRYWALL, CEILING, WALLS, TILE, TOILETS, LIGHTS	2015	37,715	400	27.5	400		400	20
21	INSTALL ONE NEW CIRCUIT BREAKER LOAD CENTER								21
22	FOR EMERGENCY/LIFE SAFETY NEEDS	2015	6,500	49	27.5	49		49	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,070,749	\$ 39,855		\$ 40,510	\$ 655	\$ 1,201,561	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 292,262	\$ 15,070	\$ 33,484	\$ 18,414	5-10	\$ 160,232	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	301,050					301,050	73
74								74
75	TOTALS	\$ 593,312	\$ 15,070	\$ 33,484	\$ 18,414		\$ 461,282	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2066 CHRYSLER VAN	2005	\$ 43,880	\$ 1,675	\$	\$ (1,675)		\$ 43,880	76
77										77
78										78
79										79
80	TOTALS			\$ 43,880	\$ 1,675	\$	\$ (1,675)		\$ 43,880	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 2,876,846	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 56,600	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,994	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,394	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,706,723	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

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.	_____	\$ _____

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: \$ 3,673 Description: KONICA MINOLTA-COPIER MACHINE
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					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.

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			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	\$				\$ 29,726	\$			\$ 29,726	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs					8,886				8,886	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39-3	hrs					44,313				44,313	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39-2	# of prescripts						23,132			23,132	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			\$				\$ 82,925	\$ 23,132			\$ 106,057	14	

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number **THE WESTWOOD MANOR**# **0005249**Report Period Beginning: **01/01/2015**

Ending:

12/31/2015**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2015**

(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	\$ 216,736	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	657,509		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,995		6
7	Other Prepaid Expenses	4,017		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Escrow Deposit	70,979		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,038,236	\$	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	1,886,577		15
16	Equipment, at Historical Cost	658,581		16
17	Accumulated Depreciation (book methods)	(1,727,614)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,145,726	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,183,962	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 367,526	\$	26
27	Officer's Accounts Payable	93,494		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	486,086		29
30	Accrued Salaries Payable	28,697		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,935		31
32	Accrued Real Estate Taxes(Sch.IX-B)	136,404		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,144,142	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	586,667		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)	\$ 586,667	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,730,809	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 453,153	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,183,962	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 329,401	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 329,406	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	363,772	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(240,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES	(25)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 123,747	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)	\$ 453,153	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,400,044	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,400,044	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 4,400,044	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	918,975	31
32	Health Care	1,492,439	32
33	General Administration	985,440	33
B. Capital Expense			
34	Ownership	248,311	34
C. Ancillary Expense			
35	Special Cost Centers	106,057	35
36	Provider Participation Fee	282,791	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,034,013	40
41	Income before Income Taxes (line 30 minus line 40)**	366,031	41
42	Income Taxes	(2,259)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 363,772	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,992,604	44
45	Private Pay - Net Inpatient Revenue	66,690	45
46	Medicare - Net Inpatient Revenue	340,750	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,400,044	49

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

- * This must agree with page 4, line 45, column 4.
- ** Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.
- *** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
- ****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

0005249

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	13,687	14,399	427,248	29.67	3
4	Licensed Practical Nurses	8,856	9,663	262,421	27.16	4
5	CNAs & Orderlies	40,767	44,032	501,324	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,172	5,539	58,400	10.54	10
11	Social Service Workers	6,416	6,853	102,340	14.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,119	17,580	207,403	11.80	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	8,457	9,461	97,912	10.35	18
19	Laundry					19
20	Administrator	4,160	4,392	133,478	30.39	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	128,079	61.58	22
23	Office Manager					23
24	Clerical	4,808	5,061	58,954	11.65	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)	110,522	119,060	\$ 1,977,559 *	\$ 16.61	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	\$ 21,671	1-3	35
36	Medical Director	O	14,200	9-3	36
37	Medical Records Consultant	N	4,030	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,840	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,400	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 52,141		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

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9						N/A						
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number THE WESTWOOD MANOR

0005249

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,012 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. \$ 282,791
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.