

		FOR BHF USE					

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**2016**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2016)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0005249</u></p> <p><b>Facility Name:</b> <u>THE WESTWOOD MANOR</u></p> <p><b>Address:</b> <u>2444 WEST TOUHY AVE</u> <u>CHICAGO</u> <u>60645</u>          Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>(773) 274-7705</u> <b>Fax #</b> <u>(774) 274-6173</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>1960</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>SANFORD BOKOR</u> <b>Telephone Number:</b> <u>(847) 675-3585</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>JOSEPH LIBERMAN</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>EXECUTIVE DIRECTOR</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>JOSEPH LIBERMAN</u> (Date) _____		(Title) <u>EXECUTIVE DIRECTOR</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u>	(Firm Name & Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number THE WESTWOOD MANOR

# 0005249 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

**III. STATISTICAL DATA**

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

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

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			702	702	8
9	SNF/PED					9
10	ICF	36,341	331		36,672	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,341	331	702	37,374	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 88.80%

**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 702

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: 12/31/2016 Fiscal Year: 12/31/2016

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



V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	21,365
	REPAIRS & MAINTENANCE	5,910
		27,275
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	1,929
		1,929
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	19,778
	ELECTRICITY	39,975
	WATER	27,673
	CABLE TV - LOBBY	3,253
		90,679
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	8,553
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	4,787
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,484
	FIRE SERVICE	5,401
		22,225
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	15,057
	SECURITY SERVICE	0
		15,057
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	15,200
		15,200

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	1,060
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	6,804
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,610
	PHARMACY CONSULTANT XVIII B 39-2	9,768
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		20,242
<b>10a</b>	<b>THERAPY</b>	
	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
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,400
		2,400
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
		0
18	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
		0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	37,583
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	43,307
		80,890
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	16,675
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	2,799
	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	
	PATIENT BACKGROUND CHECKS XIX F	1,500
		21,285
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,209
	EQUIPMENT REPAIR & MAINTENANCE	8,614
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	1,400
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	10,389
	MESSENGER SERVICE	0
		26,612

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	166,936
	UNEMPLOYMENT COMPENSATION XIX D	37,130
	WORKERS COMPENSATION INSURANCE XIX D	55,986
	HOSPITALIZATION INSURANCE XIX D	102,527
	EMPLOYEE BENEFITS - OTHER XIX D	2,576
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
		365,155
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,290
		1,290
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	3,420
		3,420
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	0
		0
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	86,528
		86,528
27	<b>OTHER</b>	
	BAD DEBTS VI 24	200,000
		200,000

GRAND TOTAL COLUMN 3 OTHER

980,187

**THE WESTWOOD MANOR  
SCHEDULES  
12/31/2016**

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

TOTAL FOOD PURCHASE	270,210
LESS SALES TAX	<u>0</u>
NET FOOD	270,210

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

TOTAL PATIENT CENSUS	37,374
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	112,122

ADD # EMPLOYEE MEALS/DAY TIMES # DAYS	<u>9,516</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	112,122
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	112,122

NET FOOD	270,210
DIVIDE TOTAL MEALS/YEAR	<u>112,122</u>

COST PER MEAL	2.41
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

Facility Name &amp; ID Number

THE WESTWOOD MANOR

#0005249

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## 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	
	<b>D. Ownership</b>											
30	Depreciation			57,797	57,797		57,797	17,176	74,973			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,930	53,930		53,930	(2,862)	51,068			32
33	Real Estate Taxes			68,098	68,098		68,098		68,098			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,121	4,121		4,121		4,121			35
36	Other (specify):*			93	93		93		93			36
37	<b>TOTAL Ownership</b>			184,039	184,039		184,039	14,314	198,353			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,137	78,676	96,813		96,813		96,813			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			285,733	285,733		285,733		285,733			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		18,137	364,409	382,546		382,546		382,546			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,124,598	653,615	1,528,635	4,306,848		4,306,848	(246,292)	4,060,556			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	17,176	30		9
10	Interest and Other Investment Income	(2,862)	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	(1,400)	21		18
19	Entertainment		20		19
20	Contributions		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	(200,000)	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 SEE PG 5A	(58,895)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (246,292)		\$	30

**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	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (246,292)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

THE WESTWOOD MANOR

ID# 0005249

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (56,131)	21	1
2	MARKETING EXPENSES	(2,764)	21	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
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26				26
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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	<b>Total</b>	(58,895)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number THE WESTWOOD MANOR

# 0005249

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## 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	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(311)	0	0	0	0	0	0	0	0	0	0	(311)	20
21	Clerical & General Office Expenses	(60,295)	0	0	0	0	0	0	0	0	0	0	(60,295)	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):*	(200,000)	0	0	0	0	0	0	0	0	0	0	(200,000)	27
28	<b>TOTAL General Administration</b>	<b>(260,606)</b>	<b>0</b>	<b>(260,606)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(260,606)</b>	<b>0</b>	<b>(260,606)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE WESTWOOD MANOR# 0005249

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	17,176	0	0	0	0	0	0	0	0	0	0	17,176	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,862)	0	0	0	0	0	0	0	0	0	0	(2,862)	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	<b>TOTAL Ownership</b>	<b>14,314</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>14,314</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(246,292)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(246,292)</b>	<b>45</b>

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

# **0005249**

Report Period Beginning: **01/01/2016** Ending: **12/31/2016**

**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	<b>Total</b>		\$			\$	\$ *	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:

01/01/2016

Ending:

12/31/2016

**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 &amp; ID Number

THE WESTWOOD MANOR

# 0005249

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## 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	100.00	SALARY	\$ 128,429	17-1	1
2											2
3	YAFA LIBERMAN	DIETARY	DIETARY			40	100.00	SALARY	19,500	1-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 147,929		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:

01/01/2016

Ending: 2/31/2016

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

THE WESTWOOD MANOR

# 0005249

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

**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	Name of Lender	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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	MB FINANCIAL	X		WORKING CAPITAL	\$4,444.44	10/15/11	\$ 800,000		10/15/16	4.5000	\$ 28,407	1						
2												2						
3	MB FINANCIAL	X		WORKING CAPITAL	\$8,046.56	06/05/13	873,133		06/05/18	5.2500	21,167	3						
4												4						
5												5						
<b>Working Capital</b>																		
6	MB FINANCIAL	X		WORKING CAPITAL	DEMAND	REVOLV	800,000	150,000		PRIME+	2,460	6						
7												7						
8		X		INSURANCE FINANCE							1,896	8						
9	TOTAL Facility Related				\$12,491.00		\$ 2,473,133	\$ 150,000			\$ 53,930	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,473,133	\$ 150,000			\$ 53,930	15						

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

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2015 report.		\$	<b>136,404</b>	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.)		\$	<b>127,846</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(8,558)</b>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>129,120</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ <u>52,464</u> For <u>2013</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>(52,464)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>68,098</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<b>111,580</b>	8
	2012	<b>130,619</b>	9
	2013	<b>132,387</b>	10
	2014	<b>135,054</b>	11
	2015	<b>127,846</b>	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 2015 TAX BILL.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.**

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME THE WESTWOOD MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0005249

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-25-427-035-0000</u>	<u>NURSING HOME</u>	\$ <u>117,508.79</u>	\$ <u>117,508.79</u>
2. <u>10-25-427-010-0000</u>	<u>NURSING HOME</u>	\$ <u>10,337.10</u>	\$ <u>10,337.10</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>127,845.89</u></u>	\$ <u><u>127,845.89</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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:

01/01/2016 Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

Table with 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Row 1: NURSING HOME, 33,750, 1960, \$ 168,905. Row 2: (blank), (blank), (blank), (blank). Row 3: TOTALS, 33,750, (blank), \$ 168,905.

Facility Name &amp; ID Number THE WESTWOOD MANOR

# 0005249

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

**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			1963	1960	\$ 210,408	\$		\$	\$	\$ 210,408	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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.

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number THE WESTWOOD MANOR

# 0005249

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

## 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	
	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	11,335	41
42	FENCE	2002	1,464	87	15	87		1,365	42
43	REMODELING BATHROOMS	2002	8,858	322	27.5	322		4,656	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		37,621	47
48	ELEVATOR REPAIR	2005	10,500	700	15	700		8,050	48
49	DOORS	2006	1,288	79	10	79		1,288	49
50	AIRCONDITIONER REPAIRS	2006	3,727		5			3,727	50
51	FLOORING	2006	130,000	4,727	27.5	4,727		48,255	51
52	NURSES CALL SYSTEM	2006	6,000		5			6,000	52
53	BATHROOMS REMODELING	2007	9,000	327	27.5	327		3,202	53
54	TUCKPOINTING	2007	4,000	145	27.5	145		1,359	54
55	AWNING	2007	4,845	176	27.5	176		1,753	55
56	INSTALL NEW SINGLE PLY MODIFIED BUTUMEN ROOF	2008	67,000	2,436	27.5	2,436		21,011	56
57	INSTALL DOMESTIC WATER SYSTEM BOOSTER PUMP	2008	12,000	436	27.5	436		3,506	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		1,462	59
60	INSTALLED 2 NEW BOILERS	2009	41,950	1,525	27.5	1,525		10,739	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		4,435	62
63	REMODEL BATHROOM #111 WITH NEW TILE FLOOR	2010	4,550	165	27.5	165		1,093	63
64	INSTALL 28 COUNTER TOPS	2010	5,323	194	27.5	194		1,221	64
65	PAINTING OF CABINETS	2010	21,661		5			21,661	65
66	NEW GRRENHOUSE-INSTALLATION OF FOUNDATION,	2010	46,805	1,702	27.5	1,702		10,708	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	\$ 17,016		\$ 17,671	\$ 655	\$ 1,161,674	70

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

Facility Name &amp; ID Number THE WESTWOOD MANOR

# 0005249

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,495,773	\$ 17,016		\$ 17,671	\$ 655	\$ 1,161,674	1
2	INSTALL NEW THERMOSTAT, CHARGE OVER SWITCHES	2010	27,096	985	27.5	985		5,869	2
3	INSTALL NEW MIXING VALVES IN TUB & SHOWER ROOM	2011	11,113	404	27.5	404		2,407	3
4	BUILD NEW STORAGE SHED INCLUDES FIBERGLASS,								4
5	SHINGLES AND VINYL SIDING WITH TWO DOORS	2011	9,370	341	27.5	341		1,918	5
6	REMODEL RECEPTION AREA: INSTALL DROPPED CEILING,								6
7	LIGHTS, FAN,COUNTER TOPS,CHAIR RAIL,NEW SHELVING								7
8	UNIT, SWITCHES AND OUTLETS, PAINTING WALLS	2011	14,864	541	27.5	541		3,043	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		4,549	12
13	INSTALL NEW PUMP CONTOLLER	2011	4,600	167	27.5	167		898	13
14	BUILD NEW CONCRETE SIDEWALK, INSTALL METAL POS	2011	5,588	373	15	373		1,927	14
15	ADDITION OF SPRINKLER HEADS IN SKY LIGHTS	2011	2,520	92	27.5	92		472	15
16	RELOCATION OF WIRES TO PREVENT FLOOD DAMAGE	2011	5,000	182	27.5	182		933	16
17	BATHROOM-DEMO SHOWER WALLS AND FLOOR	2012	6,405	233	27.5	233		1,078	17
18	FURNISH & INSTALL NEW 2 TON AIR CONDITION UNIT	2012	7,000	255	27.5	255		1,201	18
19	LIGHTING RETROFIT TO INCREASE THE ENERGY EFFICI	2012	14,242	518	27.5	518		2,353	19
20	WINDOW TREATMENTS INSTALLATION	2012	3,570	411	5	411		3,363	20
21	SEALCOATING OF THE PARKING LOT	2012	2,945	196	15	196		849	21
22	INSTALL ADDITIONAL SUBPANEL(RESIDENTIAL GRADE)	2012	4,250	155	27.5	155		652	22
23	KITCHEN POT AND PAN AREA: DEMO DRYWALL,ROD	2012	10,921	397	27.5	397		1,638	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		469	25
26	RECEPTACLES AND PLATES								26
27	FURNISH & INSTALL HOLLOW METAL PEDESTRIAN DOOR								27
28	AND FRAME	2013	8,700	316	27.5	316		1,251	28
29	CURTAINS RECOVERED AND COMPLETE AND INSTALLEI	2013	3,170	115	27.5	115		398	29
30	INSTALLING OUTDOOR FIXTURES AND RECEPTACLES IN								30
31	RECORDS & MEETING ROOM; NEW EXIT SIGNS	2013	4,100	273	15	273		933	31
32	FIRE ALARM SYSTEM DEVICES: REPLACED TAMPER PANEL								32
33	AND ANNUNCIATOR	2013	2,832	103	27.5	103		339	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,659,664	\$ 24,016		\$ 24,671	\$ 655	\$ 1,198,214	34

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

Facility Name &amp; ID Number THE WESTWOOD MANOR

# 0005249

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,659,664	\$ 24,016		\$ 24,671	\$ 655	\$ 1,198,214	1
2	<b>GARDEN BEDS FOR RESIDENTS:BUILDING OF 4 RAISED</b>								2
3	<b>BED GARDEN &amp; ONE WHEELCHAIR ACCESSIBLE BED</b>	2013	13,220	881	15	881		2,716	3
4	<b>REMODELING : REPLACEMENT FAN COIL UNITS, INSTALLED</b>								4
5	<b>NEW FLUSH MOUNT FAN COIL UNITS IN CENTER OF.</b>								5
6	<b>DINING ROOM, NEW HOT WATER CHILLED WATER PIPING,</b>								6
7	<b>NEW CONDENSATE DRAIN PUMPS FOR FAN COIL UNITS,</b>								7
8	<b>NEW ROOF CURBS, NEW SUPPLY DUCTING, DIFFUSERS,</b>								8
9	<b>REWORKED SPRINKLER SYSTEM IN FIVE BATHROOM</b>	2013	92,565	3,366	27.5	3,366		10,238	9
10	<b>FRONT ENTRANCE, DINING ROOM,ALL HALLWAYS,</b>								10
11	<b>CONFERENCE ROOM, THERAPY ROOM, RESIDENT ROOMS</b>								11
12	<b>&amp; BATHROOMS:INSTALL NEW FRAMING, DRYWALL,</b>								12
13	<b>CHAIR MOLDING, PANELING AND VANIL BASE, PAINTING</b>								13
14	<b>CEILING AND WALLS, DOOR AND WALL CORNERS</b>	2013	238,015	8,655	27.5	8,655		26,326	14
15	<b>BATHROOM (SMALL) AND BATHROOM WITH SHOWER:</b>								15
16	<b>INSTALL NEW CEILING DRYWALL, FLOOR AND WALL TILE,</b>								16
17	<b>NEW WATER LINE, PAINTING, DOOR CASING</b>	2015	20,356	740	27.5	740		1,388	17
18	<b>INSTALL CUBICLE CURTAIN</b>	2015	2,714	868	5	868		1,411	18
19	<b>MEN'S BATHROOM: INSTALLATION NEW FRAMING,</b>								19
20	<b>DRYWALL, CEILING, WALLS, TILE, TOILETS, LIGHTS</b>	2015	37,715	1,371	27.5	1,371		1,771	20
21	<b>INSTALL ONE NEW CIRCUIT BREAKER LOAD CENTER</b>								21
22	<b>FOR EMERGENCY/LIFE SAFETY NEEDS</b>	2015	6,500	236	27.5	236		285	22
23	<b>REMODELING BATHROOMS:INSTALL NEW DRYWALL,</b>	2016	41,204	1,061	27.5	1,061		1,061	23
24	<b>FLOOR,WALLS, SHOWER BASE, CAN LIGHTS, TOILET</b>								24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,111,953	\$ 41,194		\$ 41,849	\$ 655	\$ 1,243,410	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	\$ 272,964	\$ 8,104	\$ 32,583	\$ 24,479	5-10	\$ 173,517	71
72	Current Year Purchases	9,487	6,824	541	(6,283)	8-10	541	72
73	Fully Depreciated Assets	320,348					320,348	73
74								74
75	TOTALS	\$ 602,799	\$ 14,928	\$ 33,124	\$ 18,196		\$ 494,406	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 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)	\$ 2,927,537	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 57,797	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,973	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,176	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,781,696	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	<b>TOTAL</b>				\$			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: \$ 4,121 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			<u>N/A</u>		18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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? <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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 21,823	\$		\$ 21,823	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			18,106			18,106	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			38,747			38,747	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				18,137		18,137	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	<b>TOTAL</b>			\$		\$ 78,676	\$ 18,137		\$ 96,813	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 **12/31/2016**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 37,164	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	787,758		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,796		6
7	Other Prepaid Expenses	6,152		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Real Estate Escrow Deposit</b>	74,577		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,004,447	\$	10
	<b>B. Long-Term Assets</b>			
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	1,927,782		15
16	Equipment, at Historical Cost	668,068		16
17	Accumulated Depreciation (book methods)	(1,785,411)		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 (spe <b>Loan Costs</b> )	11,145		22
23	Other(specify): <b>Amort of Loan Costs</b>	(93)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,149,673	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,154,120	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 255,384	\$	26
27	Officer's Accounts Payable	93,494		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	150,000		29
30	Accrued Salaries Payable	43,163		30
31	Accrued Taxes Payable (excluding real estate taxes)	38,746		31
32	Accrued Real Estate Taxes(Sch.IX-B)	129,120		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 709,907	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	884,559		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 884,559	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,594,466	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 559,654	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,154,120	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>453,153</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>453,153</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>418,305</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(311,804)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>106,501</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>559,654</b>	<b>24</b> *

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

Facility Name &amp; ID Number THE WESTWOOD MANOR

# 0005249

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,728,997	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,728,997	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,862	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,862	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,731,859	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	982,077	31
32	Health Care	1,617,489	32
33	General Administration	1,140,697	33
<b>B. Capital Expense</b>			
34	Ownership	184,039	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	96,813	35
36	Provider Participation Fee	285,733	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,306,848	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	425,011	41
42	<b>Income Taxes</b>	(6,706)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 418,305	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,356,027	44
45	Private Pay - Net Inpatient Revenue	43,030	45
46	Medicare - Net Inpatient Revenue	329,940	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,728,997	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: **01/01/2016**

Ending:

**12/31/2016**

**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	15,170	483,621	30.45	3
4	Licensed Practical Nurses	8,847	289,918	30.39	4
5	CNAs & Orderlies	39,138	498,121	11.80	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	5,340	68,260	12.13	10
11	Social Service Workers	6,547	116,302	16.28	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	16,914	223,021	12.08	15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	9,497	113,019	10.69	18
19	Laundry				19
20	Administrator	2,080	86,279	37.32	20
21	Assistant Administrator				21
22	Other Administrative	2,080	128,429	61.74	22
23	Office Manager				23
24	Clerical	6,771	117,628	16.91	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	112,384	2,124,598 *	17.59	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	\$ 21,365	1-3	35
36	Medical Director	15,200	9-3	36
37	Medical Records Consultant	2,610	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	9,768	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	2,400	11-3	44
45	Social Service Consultant	0	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 51,343		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



**THE WESTWOOD MANOR  
SCHEDULE-LEGAL  
12/31/2016**

Facility Name &amp; ID Number THE WESTWOOD MANOR

# 0005249

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

**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? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 285,733  
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