

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

<p>I. IDPH License ID Number: <u>0005249</u></p> <p>Facility Name: <u>WESTWOOD MANOR, INC.</u></p> <p>Address: <u>2444 W. TOUHY AVE.</u> <u>CHICAGO</u> <u>60645</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 274-7705</u> Fax # <u>(773) 274-6173</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1960</u></p> <p>Type of Ownership:</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>IRS Exemption Code _____</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>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2018</u> to <u>12/31/2018</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">Officer or Administrator of Provider</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">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>KATHLEEN MCNAMARA</u> <u>VICE-PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & 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>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>JOSEPH LIBERMAN</u> (Date) _____		(Title) <u>EXECUTIVE DIRECTOR</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>KATHLEEN MCNAMARA</u> <u>VICE-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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<p>In the event there are further questions about this report, please contact: Name: <u>KATHLEEN MCNAMARA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>																																		

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			925	925	8
9	SNF/PED					9
10	ICF	5,460	703	29,760	35,923	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,460	703	30,685	36,848	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.79%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 925

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number WESTWOOD MANOR, INC. # 0005249 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	255,860	139,741	29,115	424,716		424,716		424,716		1
2	Food Purchase		256,628		256,628		256,628		256,628		2
3	Housekeeping	170,753	66,535		237,288		237,288		237,288		3
4	Laundry		10,856	4,246	15,102		15,102		15,102		4
5	Heat and Other Utilities			78,919	78,919		78,919		78,919		5
6	Maintenance		48,738	18,035	66,773		66,773		66,773		6
7	Other (specify):*			13,112	13,112		13,112		13,112		7
8	TOTAL General Services	426,613	522,498	143,427	1,092,538		1,092,538		1,092,538		8
	B. Health Care and Programs										
9	Medical Director			13,100	13,100		13,100		13,100		9
10	Nursing and Medical Records	1,601,381	115,851	37,510	1,754,742		1,754,742		1,754,742		10
10a	Therapy										10a
11	Activities	71,739	15,718	2,466	89,923		89,923		89,923		11
12	Social Services	110,374			110,374		110,374		110,374		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,783,494	131,569	53,076	1,968,139		1,968,139		1,968,139		16
	C. General Administration										
17	Administrative	220,164			220,164		220,164		220,164		17
18	Directors Fees										18
19	Professional Services			94,374	94,374		94,374		94,374		19
20	Dues, Fees, Subscriptions & Promotions			20,103	20,103		20,103	(1,455)	18,648		20
21	Clerical & General Office Expenses	159,035	22,949	20,074	202,058		202,058	(61,329)	140,729		21
22	Employee Benefits & Payroll Taxes			420,630	420,630		420,630		420,630		22
23	Inservice Training & Education			1,749	1,749		1,749		1,749		23
24	Travel and Seminar			726	726		726		726		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			96,081	96,081		96,081		96,081		26
27	Other (specify):*			6,480	6,480		6,480	(6,480)			27
28	TOTAL General Administration	379,199	22,949	660,217	1,062,365		1,062,365	(69,264)	993,101		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,589,306	677,016	856,720	4,123,042		4,123,042	(69,264)	4,053,778		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	21,508
	REPAIRS & MAINTENANCE	7,607
		29,115
3	HOUSEKEEPING	
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	4,246
		4,246
5	HEAT & OTHER UTILITIES	
	GAS HEAT	22,273
	ELECTRICITY	31,356
	WATER	20,766
	CABLE TV - LOBBY	4,524
		78,919
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,499
	PAINTING & DECORATING	
	BUILDING REPAIRS	
	MAINTENANCE TRAVEL	
	EQUIPMENT MAINTENANCE & REPAIR	2,598
	ELEVATOR MAINTENANCE & REPAIR	594
	OUTSIDE LABOR	
	EXTERMINATING SERVICE	4,000
	FIRE SERVICE	5,344
		18,035
7	OTHER	
	SCAVENGER	13,112
	SECURITY SERVICE	
		13,112
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	13,100

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	1,378
	PURCHASED SERVICES	
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	5,472
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,400
	PHARMACY CONSULTANT XVIII B 39-2	10,118
	UTILIZATION REVIEW FEES XVIII B __-2	
	PHYSICIANS XVIII B __-2	
	PSYCHIATRIC XVIII B -2	
	RN CONSULTANT XVIII B 38-2	
	DENTAL SERVICE	18,142
		37,510
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	
	OCCUPATIONAL THERAPY SERVICES	
	REHABILITATION CONSULTANT XVIII B __-2	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	
	SPEECH THERAPY CONSULTANT XVIII B 43-2	
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,466
		2,466
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	
	SOCIAL WORKER XVIII B 45-2	
		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
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	51,448
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	42,926
		94,374
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	
	EMPLOYEE RECRUITMENT/WANT ADS XIX F	10,652
	CONTRIBUTIONS VI 20 XIX F	1,260
	DUES & SUBSCRIPTIONS XIX F	4,456
	LICENSES & PERMITS XIX F	2,240
	PUBLIC RELATIONS-PATIENT RELATED XIX F	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	195
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	
	HEALTH CARE WORKER BACKGROUND CHECKS XIX F	910
	PATIENT BACKGROUND CHECKS XIX F	390
		20,103
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,032
	EQUIPMENT REPAIR & MAINTENANCE	4,834
	OUTSIDE CLERICAL SERVICES	
	PENALTIES / OVERDRAFT CHARGES VI 18	
	HOME OFFICE EXPENSE	
	THEFT & DAMAGE LOSS	
	TELEPHONE	10,208
	MESSENGER SERVICE	
		20,074

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	197,424
	UNEMPLOYMENT COMPENSATION XIX D	45,877
	WORKERS COMPENSATION INSURANCE XIX D	49,794
	HOSPITALIZATION INSURANCE XIX D	124,472
	EMPLOYEE BENEFITS - OTHER XIX D	3,063
	EMPLOYEE PHYSICAL EXAMS XIX D	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	
	PENSION/PROFIT SHARING PLANS XIX D	
		420,630
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,749
		1,749
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	726
		726
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	96,081
		96,081
27	OTHER	
	BAD DEBTS VI 24	6,480
		6,480

GRAND TOTAL COLUMN 3 OTHER 856,720

WESTWOOD MANOR, INC.
SCHEDULES
12/31/2018

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

TOTAL FOOD PURCHASE	256,628
LESS SALES TAX	<u>0</u>
NET FOOD	256,628

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

TOTAL PATIENT CENSUS	36,848
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	110,544

ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	<u>9,490</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	110,544
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	110,544

NET FOOD	256,628
DIVIDE TOTAL MEALS/YEAR	<u>110,544</u>

COST PER MEAL	2.32
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFIC	<u><u>0</u></u>

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			73,645	73,645		73,645	14,834	88,479			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			95,067	95,067		95,067		95,067			32
33	Real Estate Taxes			125,449	125,449		125,449		125,449			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,853	4,853		4,853		4,853			35
36	Other (specify):*											36
37	TOTAL Ownership			299,014	299,014		299,014	14,834	313,848			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,544	203,746	233,290		233,290		233,290			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			281,013	281,013		281,013		281,013			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		29,544	484,759	514,303		514,303		514,303			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,589,306	706,560	1,640,493	4,936,359		4,936,359	(54,430)	4,881,929			45

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

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	14,834	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				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	(195)	20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,260)	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	(6,480)	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				28
29	Other-Attach Schedule SEE PG 5A	(61,329)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,430)		\$	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	
		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))	\$ (54,430)		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

BHF USE ONLY							
48		49		50		51	

ID# 0005249

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (55,996)	21	1
2	MARKETING EXPENSES	(5,333)	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
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(61,329)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,455)	0	0	0	0	0	0	0	0	0	0	(1,455)	20
21	Clerical & General Office Expenses	(61,329)	0	0	0	0	0	0	0	0	0	0	(61,329)	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):*	(6,480)	0	0	0	0	0	0	0	0	0	0	(6,480)	27
28	TOTAL General Administration	(69,264)	0	(69,264)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,264)	0	(69,264)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	14,834	0	0	0	0	0	0	0	0	0	0	14,834	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	14,834	0	14,834	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)	(54,430)	0	(54,430)	45									

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

WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	JOSEPH LIBERMAN	25.00						1
2	BETTY EBERT TRUST	25.00						2
3	MARLENE NADLER	25.00						3
4	ROSALIE EISENBERGER	22.20						4
5	ROSALIE EISENBERGER CUST. FOR							5
6	SHLOMO M. EISENBERGER	1.40						6
7	ROSALIE EISENBERGER CUST. FOR							7
8	YOSEF Z. EISENBERGER	1.40						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

Facility Name & ID Number

WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	\$ 128,079	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	\$ 147,579		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

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

WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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			
A. Directly Facility Related																		
Long-Term																		
1	MB FINANCIAL	X		WORKING CAPITAL	\$7,371.32	12/30/16	\$ 884,559	\$ 707,647	12/15/2026	5.0000	\$ 46,792	1						
2												2						
3	LOAN COSTS	X		LOAN COSTS	W/O OVER LOAN		11,145	8,822			1,115	3						
4												4						
5												5						
Working Capital																		
6	MB FINANCIAL	X		WORKING CAPITAL	DEMAND		800,000	760,000		PRIME+	45,199	6						
7												7						
8		X		INSURANCE FINANCE							1,961	8						
9	TOTAL Facility Related				\$7,371.32		\$ 1,695,704	\$ 1,476,469			\$ 95,067	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,695,704	\$ 1,476,469			\$ 95,067	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 2017 report.	\$	141,132	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.)	\$	150,188	2
3. Under or (over) accrual (line 2 minus line 1).	\$	9,056	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	151,680	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>35,287</u> For <u>2015</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	(35,287)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	125,449	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	132,387	8
	2014	135,054	9
	2015	127,846	10
	2016	139,736	11
	2017	150,188	12

FOR BHF USE ONLY

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BACED ON ~101% OF THE PRIOR YEAR REAL ESTATE TAX BILL- THE PAYMENT ON LINE 2 APPLIED TO THE 2017 TAX BILL	13	FROM R. E. TAX STATEMENT FOR 2017	\$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTWOOD MANOR, INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0005249

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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>138,044.55</u>	\$ <u>138,044.55</u>
2. <u>10-25-427-010-0000</u>	<u>NURSING HOME</u>	\$ <u>12,143.59</u>	\$ <u>12,143.59</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>150,188.14</u></u>	\$ <u><u>150,188.14</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018 Ending:

12/31/2018

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:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: NURSING HOME, 33,750, 1960, \$ 168,905, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 33,750, (blank), \$ 168,905, 3.

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018

Ending:

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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	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
	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.

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

See Page 12A, Line 70 for total

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018 Ending: 12/31/2018

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	12,645	41
42	FENCE	2002	1,464		15	55	55	1,464	42
43	REMODELING BATHROOMS	2002	8,858	322	27.5	322		5,300	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		43,913	47
48	ELEVATOR REPAIR	2005	10,500	700	15	700		9,450	48
49	DOORS	2006	1,288		10			1,288	49
50	AIRCONDITIONER REPAIRS	2006	3,727		5			3,727	50
51	FLOORING	2006	130,000	4,727	27.5	4,727		57,709	51
52	NURSES CALL SYSTEM	2006	6,000		5			6,000	52
53	BATHROOMS REMODELING	2007	9,000	327	27.5	327		3,856	53
54	TUCKPOINTING	2007	4,000	145	27.5	145		1,649	54
55	AWNING	2007	4,845	176	27.5	176		2,105	55
56	INSTALL NEW SINGLE PLY MODIFIED BUTUMEN ROOF	2008	67,000	2,436	27.5	2,436		25,883	56
57	INSTALL DOMESTIC WATER SYSTEM BOOSTER PUMP	2008	12,000	436	27.5	436		4,378	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		1,854	59
60	INSTALLED 2 NEW BOILERS	2009	41,950	1,525	27.5	1,525		13,789	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		5,741	62
63	REMODEL BATHROOM #111 WITH NEW TILE FLOOR	2010	4,550	165	27.5	165		1,423	63
64	INSTALL 28 COUNTER TOPS	2010	5,323	194	27.5	194		1,609	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		14,112	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	\$ 16,850		\$ 17,560	\$ 710	\$ 1,196,783	70

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

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018 Ending: 12/31/2018

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	Totals from Page 12A, Carried Forward		\$ 1,495,773	\$ 16,850		\$ 17,560	\$ 710	\$ 1,196,783	1
2	INSTALL NEW THERMOSTAT, CHARGE OVER SWITCHES	2010	27,096	985	27.5	985		7,839	2
3	INSTALL NEW MIXING VALVES IN TUB & SHOWER ROOM	2011	11,113	404	27.5	404		3,215	3
4	BUILD NEW STORAGE SHED INCLUDES FIBERGLASS,								4
5	SHINGLES AND VINYL SIDING WITH TWO DOORS	2011	9,370	341	27.5	341		2,600	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		4,125	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 PAVEMENT	2011	12,405	827	15	827		6,203	12
13	INSTALL NEW PUMP CONTROLLER	2011	4,600	167	27.5	167		1,232	13
14	BUILD NEW CONCRETE SIDEWALK, INSTALL METAL POS	2011	5,588	373	15	373		2,673	14
15	ADDITION OF SPRINKLER HEADS IN SKY LIGHTS	2011	2,520	92	27.5	92		656	15
16	RELOCATION OF WIRES TO PREVENT FLOOD DAMAGE	2011	5,000	182	27.5	182		1,297	16
17	BATHROOM-DEMO SHOWER WALLS AND FLOOR	2012	6,405	233	27.5	233		1,544	17
18	FURNISH & INSTALL NEW 2 TON AIR CONDITION UNIT	2012	7,000	255	27.5	255		1,711	18
19	LIGHTING RETROFIT TO INCREASE THE ENERGY EFFICI	2012	14,242	518	27.5	518		3,389	19
20	WINDOW TREATMENTS INSTALLATION	2012	3,570		5			3,570	20
21	SEALCOATING OF THE PARKING LOT	2012	2,945	196	15	196		1,241	21
22	INSTALL ADDITIONAL SUBPANEL (RESIDENTIAL GRADE)	2012	4,250	155	27.5	155		962	22
23	KITCHEN POT AND PAN AREA: DEMO DRYWALL, ROD	2012	10,921	397	27.5	397		2,432	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		704	25
26	RECEPTACLES AND PLATES								26
27	FURNISH & INSTALL HOLLOW METAL PEDESTRIAN DOOR								27
28	AND FRAME	2013	8,700	316	27.5	316		1,883	28
29	CURTAINS RECOVERED AND COMPLETE AND INSTALLE	2013	3,170	115	27.5	115		628	29
30	INSTALLING OUTDOOR FIXTURES AND RECEPTACLES IN								30
31	RECORDS & MEETING ROOM; NEW EXIT SIGNS	2013	4,100	273	15	273		1,479	31
32	FIRE ALARM SYSTEM DEVICES: REPLACED TAMPER PANEL								32
33	AND ANNUNCIATOR	2013	2,832	103	27.5	103		545	33
34	TOTAL (lines 1 thru 33)		\$ 1,659,664	\$ 23,439		\$ 24,149	\$ 710	\$ 1,246,711	34

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

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018 Ending: 12/31/2018

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	Totals from Page 12B, Carried Forward		\$ 1,659,664	\$ 23,439		\$ 24,149	\$ 710	\$ 1,246,711	1
2	GARDEN BEDS FOR RESIDENTS:BUILDING OF 4 RAISED								2
3	BED GARDEN & ONE WHEELCHAIR ACCESSIBLE BED	2013	13,220	881	15	881		4,478	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		16,970	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		43,636	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	740	27.5	740		2,868	17
18	INSTALL CUBICLE CURTAIN	2015	2,714	313	5	313		2,245	18
19	MEN'S BATHROOM: INSTALLATION NEW FRAMING,								19
20	DRYWALL, CEILING, WALLS, TILE, TOILETS, LIGHTS	2015	37,715	1,371	27.5	1,371		4,513	20
21	INSTALL ONE NEW CIRCUIT BREAKER LOAD CENTER								21
22	FOR EMERGENCY/LIFE SAFETY NEEDS	2015	6,500	236	27.5	236		757	22
23	REMODELING BATHROOMS:INSTALL NEW DRYWALL,	2016	41,204	1,498	27.5	1,498		4,057	23
24	FLOOR,WALLS, SHOWER BASE, CAN LIGHTS, TOILET								24
25	HALLWAY BATHROOM-REMODELING-INSTALL FLOOR,	2017	45,541	1,656	27.5	1,656		2,691	25
26	CEILING, PAINTING WALLS, REPLACE DOOR, SHOWER								26
27	PIPING REPLACEMENT, MECHANICAL INSULATION TO	2017	105,762	3,866	27.5	3,866		4,027	27
28	INSULATE NEW CHWS/CHWR PIPING ON ROOF								28
29	INSTALLED NEW TRANE CHILER	2018	84,240	1,404	27.5	1,404		1,404	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,347,496	\$ 47,425		\$ 48,135	\$ 710	\$ 1,334,357	34

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

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	\$ 257,365	\$ 11,194	\$ 28,139	\$ 16,945	5-10	\$ 190,973	71
72	Current Year Purchases	8,251	8,251	413	(7,838)	5-10	413	72
73	Fully Depreciated Assets	363,447					363,447	73
74								74
75	TOTALS	\$ 629,063	\$ 19,445	\$ 28,552	\$ 9,107		\$ 554,833	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	FACILITY	2017 GMC ACADIA	2017	58,958	5,100	11,792	6,692	5	11,792	77
78										78
79										79
80	TOTALS			\$ 102,838	\$ 6,775	\$ 11,792	\$ 5,017		\$ 55,672	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)	\$ 3,248,302	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 73,645	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,479	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,834	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,944,862	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: \$ 4,853 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	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? <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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 83,337	\$		\$ 83,337	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			32,472			32,472	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			87,937			87,937	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 prescrpts				29,544		29,544	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			\$		\$ 203,746	\$ 29,544		\$ 233,290	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 12/31/2018

(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	\$ 428	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,610,078		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	102,920		6
7	Other Prepaid Expenses	5,811		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Escrow Deposit	77,158		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,796,395	\$	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	2,163,325		15
16	Equipment, at Historical Cost	753,290		16
17	Accumulated Depreciation (book methods)	(1,915,422)		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 (spec Loan Costs)	11,145		22
23	Other(specify): Amort of Loan Costs	(2,323)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,338,197	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,134,592	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 373,080	\$	26
27	Officer's Accounts Payable	113,494		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	760,000		29
30	Accrued Salaries Payable	73,295		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,107		31
32	Accrued Real Estate Taxes(Sch.IX-B)	151,680		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)	\$ 1,515,656	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	707,647		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Auto Loan	49,951		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 757,598	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,273,254	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 861,338	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,134,592	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 607,978	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 607,976	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	457,541	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	(195,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES	(9,179)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 253,362	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)	\$ 861,338	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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	\$ 5,391,159	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,391,159	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***	2,741	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,741	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)	\$ 5,393,900	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,092,538	31
32	Health Care	1,968,139	32
33	General Administration	1,062,365	33
B. Capital Expense			
34	Ownership	299,014	34
C. Ancillary Expense			
35	Special Cost Centers	233,290	35
36	Provider Participation Fee	281,013	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,936,359	40
41	Income before Income Taxes (line 30 minus line 40)**	457,541	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 457,541	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 736,425	44
45	Private Pay - Net Inpatient Revenue	122,891	45
46	Medicare - Net Inpatient Revenue	624,123	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>		47
48	Other-(specify) <u>MANAGED CARE</u>	3,907,720	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,391,159	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 WESTWOOD MANOR, INC.

0005249

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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	17,178	18,586	591,280	31.81	3
4	Licensed Practical Nurses	9,845	10,469	329,980	31.52	4
5	CNAs & Orderlies	46,027	49,920	680,121	13.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,261	5,687	71,739	12.61	10
11	Social Service Workers	5,740	6,420	110,374	17.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,757	19,601	255,860	13.05	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	12,488	13,561	170,753	12.59	18
19	Laundry					19
20	Administrator	2,080	2,312	92,085	39.83	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	128,079	61.58	22
23	Office Manager					23
24	Clerical	7,275	7,609	159,035	20.90	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)	125,731	136,245	\$ 2,589,306 *	\$ 19.00	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	\$ 21,508	1-3	35
36	Medical Director	O	13,100	9-3	36
37	Medical Records Consultant	N	2,400	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	10,118	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	2,466	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	Psycho-Social		5,472	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 55,064		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number WESTWOOD MANOR, INC.

0005249

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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. \$ 12,624 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. \$ 281,013
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 benefit 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