

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782 Report Period Beginning: 01/01/2004 Ending: 01/01/2004

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 180

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	180	Intermediate (ICF)	180	65,880	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,880	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	57,367	574	167	58,108	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,367	574	167	58,108	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.20%

D. How many bed-hold days during this year were paid by Public Aid? 216 (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 01/01/1990

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1989 NO

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

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/04 Fiscal Year: 12/31/04

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

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2004 Ending: 01/01/2004

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	207,303	24,180	8,880	240,363		240,363	13,785	254,148		1
2	Food Purchase		157,342		157,342	(21,405)	135,937	(221)	135,716		2
3	Housekeeping	177,417	16,370		193,787		193,787		193,787		3
4	Laundry		6,472		6,472		6,472		6,472		4
5	Heat and Other Utilities			99,983	99,983		99,983	2,499	102,482		5
6	Maintenance	9,523	64,649	76,408	150,580		150,580	22,202	172,782		6
7	Other (specify):* See Attached Sch			13,862	13,862		13,862		13,862		7
8	TOTAL General Services	394,243	269,013	199,133	862,389	(21,405)	840,984	38,265	879,249		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	978,870	16,948	1,580	997,398		997,398	188	997,586		10
10a	Therapy	25,557		1,385	26,942		26,942		26,942		10a
11	Activities	87,804	5,344		93,148		93,148		93,148		11
12	Social Services	30,007		3,463	33,470		33,470		33,470		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,122,238	22,292	6,428	1,150,958		1,150,958	188	1,151,146		16
	C. General Administration										
17	Administrative	21,844		353,757	375,601		375,601	(211,921)	163,680		17
18	Directors Fees										18
19	Professional Services			57,750	57,750		57,750	99	57,849		19
20	Dues, Fees, Subscriptions & Promotions			43,833	43,833		43,833	(14,189)	29,644		20
21	Clerical & General Office Expenses	108,062		51,752	159,814		159,814	124,309	284,123		21
22	Employee Benefits & Payroll Taxes			368,517	368,517	21,405	389,922	21,110	411,032		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,964	2,964		2,964		2,964		24
25	Other Admin. Staff Transportation			3,259	3,259		3,259	(1,492)	1,767		25
26	Insurance-Prop.Liab.Malpractice			175,038	175,038		175,038	888	175,926		26
27	Other (specify):*										27
28	TOTAL General Administration	129,906		1,056,870	1,186,776	21,405	1,208,181	(81,196)	1,126,985		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,646,387	291,305	1,262,431	3,200,123		3,200,123	(42,743)	3,157,380		29

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

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

Facility Name & ID Number

Winston Manor Cnv & Nursing

#0035782

Report Period Beginning:

01/01/2004

Ending:

01/01/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			26,289	26,289		26,289	49,888	76,177			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							305,673	305,673			33
34	Rent-Facility & Grounds			597,673	597,673		597,673	(597,673)				34
35	Rent-Equipment & Vehicles			25,805	25,805		25,805	496	26,301			35
36	Other (specify):*											36
37	TOTAL Ownership			649,767	649,767		649,767	(241,616)	408,151			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33		33		33		33			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,820	98,820		98,820		98,820			42
43	Other (specify):* Investment							11,404	11,404			43
44	TOTAL Special Cost Centers		33	98,820	98,853		98,853	11,404	110,257			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,646,387	291,338	2,011,018	3,948,743		3,948,743	(272,955)	3,675,788			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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(1,166)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(221)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,630)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(620)	21		18
19	Entertainment				19
20	Contributions	(24,980)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,320)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,760)	20		28
29	Other-Attach Schedule <u>See Attached Schedule</u>	(3,564)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (43,261)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(229,694)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (229,694)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (272,955)		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	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Winston Manor Cnv & Nursing

ID# 0035782

Report Period Beginning: 01/01/2004

Ending: 01/01/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Franchise Fee	\$ (278)	21	1
2	Franchise Fee - Management Company	(19)	21	2
3	Non Deductible Dues	(3,267)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,564)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winston Manor Cnv & Nursing# 0035782

Report Period Beginning:

01/01/2004

Ending:

01/01/2004

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	13,785	0	0	0	0	0	0	0	0	13,785	1
2	Food Purchase	(221)	0	0	0	0	0	0	0	0	0	0	(221)	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	2,499	0	0	0	0	0	0	0	0	0	2,499	5
6	Maintenance	0	968	21,234	0	0	0	0	0	0	0	0	22,202	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(221)	3,467	35,019	0	38,265	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	188	0	0	0	0	0	0	0	0	188	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	Nurse Aide 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	188	0	188	16							
	C. General Administration													
17	Administrative	0	0	(211,921)	0	0	0	0	0	0	0	0	(211,921)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	99	0	0	0	0	0	0	0	0	0	99	19
20	Fees, Subscriptions & Promotions	(14,347)	158	0	0	0	0	0	0	0	0	0	(14,189)	20
21	Clerical & General Office Expenses	(25,897)	422	149,779	5	0	0	0	0	0	0	0	124,309	21
22	Employee Benefits & Payroll Taxes	0	21,110	0	0	0	0	0	0	0	0	0	21,110	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	(1,630)	0	138	0	0	0	0	0	0	0	0	(1,492)	25
26	Insurance-Prop.Liab.Malpractice	0	888	0	0	0	0	0	0	0	0	0	888	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(41,874)	22,677	(62,004)	5	0	(81,196)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,095)	26,144	(26,797)	5	0	(42,743)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winston Manor Cnv & Nursing# 0035782

Report Period Beginning:

01/01/2004 Ending:01/01/2004

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(1,166)	0	157	50,897	0	0	0	0	0	0	0	49,888	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	305,673	0	0	0	0	0	0	0	305,673	33
34	Rent-Facility & Grounds	0	0	0	(597,673)	0	0	0	0	0	0	0	(597,673)	34
35	Rent-Equipment & Vehicles	0	496	0	0	0	0	0	0	0	0	0	496	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,166)	496	157	(241,103)	0	(241,616)	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	11,404	0	0	0	0	0	0	0	11,404	43
44	TOTAL Special Cost Centers	0	0	0	11,404	0	11,404	44						
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(43,261)	26,640	(26,640)	(229,694)	0	(272,955)	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	75.00%	Balmoral Home, Inc.	Chicago	Nivram Mgmt, Inc.	Chicag, IL	Management
Joseph Mermelstein	25.00%	Central Nursing Home, Inc.	Chicago			
		Sovereign Healthcare, L.L.C.	Chicago	Pierce Building Ptsp.	Chicago, IL	Lessor
		Chicago Ridge Nursing and Rehab Center	Chicago Ridge			

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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	21	Bank Charges	Nivram Management, Inc.	50.00%	\$ 23	\$ 23	1	
2	V	21	Office Expenses	Nivram Management, Inc.	50.00%	380	380	2	
3	V	20	Dues & Subscriptions	Nivram Management, Inc.	50.00%	158	158	3	
4	V	21	Franchise Tax	Nivram Management, Inc.	50.00%	19	19	4	
5	V	19	Accounting Fees	Nivram Management, Inc.	50.00%	99	99	5	
6	V	22	Payroll Taxes	Nivram Management, Inc.	50.00%	18,576	18,576	6	
7	V	5	Utilities	Nivram Management, Inc.	50.00%	2,499	2,499	7	
8	V	26	Insurance	Nivram Management, Inc.	50.00%	888	888	8	
9	V	6	Reparis & Maintenance	Nivram Management, Inc.	50.00%	604	604	9	
10	V	22	Health Insurance	Nivram Management, Inc.	50.00%	2,534	2,534	10	
11	V	6	Scavenger	Nivram Management, Inc.	50.00%	72	72	11	
12	V	35	Rental Equipment	Nivram Management, Inc.	50.00%	496	496	12	
13	V	6	Building Expense	Nivram Management, Inc.	50.00%	292	292	13	
14	Total		\$			\$ 26,640	\$ *	26,640	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	25 Auto Expense	\$	Nivram Management, Inc.	50.00%	\$ 138	\$	138	15
16	V	21 Postage		Nivram Management, Inc.	50.00%	369		369	16
17	V	10 Mattress Expense		Nivram Management, Inc.	50.00%	188		188	17
18	V	30 Depreciation		Nivram Management, Inc.	50.00%	157		157	18
19	V	21 Data Processing		Nivram Management, Inc.	50.00%	373		373	19
20	V	21 Telephone		Nivram Management, Inc.	50.00%	1,020		1,020	20
21	V	6 Plant Supervisor Salary		Nivram Management, Inc.	50.00%	21,234		21,234	21
22	V	17 Asst. Administrator Salary		Nivram Management, Inc.	50.00%	31,851		31,851	22
23	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	45,000		45,000	23
24	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	13,785		13,785	24
25	V	17 Administrative Salary		Nivram Management, Inc.	50.00%	46,188		46,188	25
26	V	17 Administrator Salary		Nivram Management, Inc.	50.00%	63,797		63,797	26
27	V	21 Clerical Salary		Nivram Management, Inc.	50.00%	103,017		103,017	27
28	V	17 Management Fees	353,757	Nivram Management, Inc.	50.00%			(353,757)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 353,757			\$ 327,117	\$ *	(26,640)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation	\$	Pierce Building Partnership	50.00%	\$ 50,897	\$ 50,897
16	V	33 Property Taxes		Pierce Building Partnership	50.00%	305,673	305,673
17	V	21 Bank Charges		Pierce Building Partnership	50.00%	5	5
18	V	43 Loss from Hamlin Investment		Pierce Building Partnership	50.00%	11,404	11,404
19	V	34 Rent	597,673	Pierce Building Partnership	50.00%		(597,673)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 597,673			\$ 367,979	\$ * (229,694)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2004 Ending: 01/01/2004

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	Henry Mermelstein	Administrator	Administrative	None	223,490	8	11.00%	Salary	\$ 26,510	17-7	1
2	Louise Mermelstein	Food Serv Superv	Support	None	76,215	11	13.00%	Salary	13,785	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	75.00%	87,766	4	19.00%	Salary	21,234	6-7	3
4	Doreen Mermelstein	Office Manager	Support	None	59,120	40	67.00%	Salary	45,000	21-7	4
5											5
6	Marvin Mermelstein	Administrative	Administrative	See Above	131,649	5	20.00%	Salary	31,851	17-7	6
7	Joseph Mermelstein	Administrative	Administrative	25.00%	75,322	2	21.00%	Salary	19,678	17-7	7
8											8
9		See Schedule B									9
10											10
11											11
12											12
13								TOTAL	\$ 158,058		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 Winston Manor Cnv & Nursing# 0035782

Report Period Beginning:

01/01/2004Ending: 1/01/2004

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

Name of Related Organization

Nivram Management, Inc.

Street Address

6500 N. Hamlin Ave.

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 679-7484

Fax Number

(847) 679-7494

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

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	21	Bank Charges	Resident Beds	924	5	\$ 110	\$ 180	\$ 21	1	
2	21	Office Expenses	Resident Beds	924	5	1,952	180	380	2	
3	20	Dues & Subscriptions	Resident Beds	924	5	810	180	158	3	
4	21	Franchise Tax	Resident Beds	924	5	100	180	19	4	
5	19	Accounting Fees	Resident Beds	924	5	510	180	99	5	
6	22	Payroll Taxes	Resident Beds	924	5	95,359	180	18,576	6	
7	5	Utilities	Resident Beds	924	5	12,827	180	2,499	7	
8	26	Insurance	Resident Beds	924	5	4,558	180	888	8	
9	6	Repairs & Maintenance	Resident Beds	924	5	3,103	180	604	9	
10	22	Health Insurance	Resident Beds	924	5	13,008	180	2,534	10	
11	6	Scavenger	Resident Beds	924	5	370	180	72	11	
12	35	Rental Equipment	Resident Beds	924	5	2,544	180	496	12	
13	6	Building Expense	Resident Beds	924	5	1,500	180	292	13	
14	25	Auto Expense	Resident Beds	924	5	706	180	138	14	
15	21	Postage	Resident Beds	924	5	1,895	180	369	15	
16	10	Matress Expense	Resident Beds	924	5	967	180	188	16	
17	30	Depreciation	Resident Beds	924	5	808	180	157	17	
18	21	Data Processing	Resident Beds	924	5	1,914	180	373	18	
19	21	Telephone	Resident Beds	924	5	5,238	180	1,020	19	
20	6	Plant Supervisor Salary	Direct Cost	1	1	21,234	21,234	1	21,234	20
21	17	Asst. Administrator Salary	Direct Cost	1	1	31,851	31,851	1	31,851	21
22	21	Office Manager Salary	Direct Cost	1	1	45,000	45,000	1	45,000	22
23	1	Food Service Supervisor Salary	Direct Cost	1	1	13,785	13,785	1	13,785	23
24	17	Administrative Salaries	Direct Cost	1	1	46,188	46,188	1	46,188	24
25	TOTALS					\$ 306,337	\$ 158,058	\$ 186,941	25	

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2004

Ending: 1/01/2004

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 Nivram Management, Inc.
 Street Address 6500 N. Hamlin Ave
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-7484
 Fax Number (847) 679-7494

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	17	Administrator Salary	Direct Cost	1	1	\$ 63,797	\$ 63,797	1	\$ 63,797	1
2	21	Clerical Salaries	Direct Cost	1	1	103,017	103,017	1	103,017	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					\$ 166,814	\$ 166,814		\$ 166,814	25

Facility Name & ID Number

Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2004

Ending:

01/01/2004

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		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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 2003 report.

\$ **141,000** 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.)

\$ **217,673** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **76,673** 3

4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **229,000** 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **305,673** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	185,991	8
	2000	133,451	9
	2001	136,922	10
	2002	138,457	11
	2003	217,673	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	\$	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.**

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2004 Ending:

01/01/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,192 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>1989</u>	<u>\$ 105,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 105,000	3

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2004 Ending: 01/01/2004

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	180	1989		\$ 1,536,832	\$ 48,776	31.5	\$ 48,776	\$	\$ 689,112	4
5				(30,119)						5
6										6
7										7
8										8
	Improvement Type**									
9	Security System		1990	9,200	292	31.5	292		4,344	9
10	Interior Improvement		1990	32,039	1,018	31.5	1,018		14,799	10
11	Elevator		1990	5,300	168	31.5	168		2,429	11
12	Tiling & Lobby Office		1990	10,143	322	31.5	322		4,603	12
13	Building Improvements		1991	3,230	103	31.5	103		1,389	13
14	Building Improvements		1991	4,806	153	31.5	153		2,052	14
15	Tiles		1991	11,906	377	31.5	377		4,933	15
16	Radiator Cover		1992	12,400	394	31.5	394		5,040	16
17	Electircal Work		1992	3,500	111	31.5	111		1,411	17
18	Building Improvements		1993	21,476	550	39	550		6,266	18
19	Building Improvements		1995	34,754	891	39	891		8,502	19
20	Flooring & Tile		1996	5,355	137	39	137		1,170	20
21	Generator		1996	35,589	913	39	913		7,799	21
22	Air Conditioner		1996	16,511	423	39	423		3,614	22
23	Alarm System		1996	3,744	96	39	96		820	23
24	Roof		1996	1,200	31	39	31		265	24
25	Hot Water Heater		1996	2,900	74	39	74		632	25
26	Smoke Eater		1993	4,600		10	230	230	4,600	26
27	Air Conditioner		1993	2,550		10	128	128	2,550	27
28	Carpet		1993	3,527		10	173	173	3,527	28
29	Boiler		1993	3,600		10	180	180	3,600	29
30	Air Conditioner		1994	5,122		10	512	512	4,864	30
31	Hot Water Heater		1995	4,160		10	416	416	3,540	31
32	Air Conditioner		1995	2,816		10	282	282	2,405	32
33	Glass		1995	647		10	64	64	512	33
34	Roof		1997	21,350	547	39	547		4,103	34
35	Phone System		1997	13,666	350	39	350		2,625	35
36	Electircal Work		1997	49,685	1,274	39	1,274		9,555	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2004 Ending: 01/01/2004

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Central Air Conditioning	1997	\$ 35,499	\$ 910	39	\$ 910		\$ 6,825	37
38	New Office Construction	1997	4,442	114	39	114		855	38
39	Boiler Insulation / Installation	1997	29,412	754	39	754		5,655	39
40	Fire Alarm & Sprinklers	1997	2,475	63	39	63		473	40
41	Doors & Construction	1997	8,191	210	39	210		1,575	41
42	Plumbing - Toilers, Pipes	1997	4,719	121	39	121		908	42
43	Roof	1998	3,900	100	39	100		650	43
44	HVAC Work	1998	2,700	69	39	69		449	44
45	Doors & Construction	1998	2,729	70	39	70		455	45
46	Time Clock	1998	5,244	135	39	135		752	46
47	Air Conditioner	1998	777	20	39	20		130	47
48	Phone System	1998	1,283	33	39	33		220	48
49	Door	1999	2,500	64	39	64		289	49
50	Fire Damper	1999	1,783	46	39	46		207	50
51	Water System	1999	6,000	154	39	154		693	51
52	Doors & Construction	1999	2,500	64	39	64		256	52
53	Kitchen and Tiling	1999	10,250	263	39	263		1,183	53
54	New Windows	2001	1,300	33	39	33		100	54
55	Doors and Frame	2001	2,025	53	39	53		158	55
56	Electric Wiring	2001	443	11	39	11		34	56
57	Wall Repair	2001	1,000	26	39	26		78	57
58	Roof Repair	2003	1,150	14	39	29	15	58	58
59	Brick Paver	2004	40,000	171	39	1,026	855	1,026	59
60	Tuckpointing	2004	23,518	251	39	603	352	603	60
61	Building Improvements from Building Partnership	1995	74,705	2,121	39	2,121		24,746	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,101,034	\$ 62,870		\$ 66,077	\$ 3,207	\$ 849,439	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 86,392	\$ 8,408	\$ 8,639	\$ 231	10	\$ 53,706	71
72	Current Year Purchases	10,219	5,908	1,022	(4,886)	10	1,022	72
73	Fully Depreciated Assets	413,340					413,340	73
74	Mng Comp & Bld Prtn		157	439	282	10	805	74
75	TOTALS	\$ 509,951	\$ 14,473	\$ 10,100	\$ (4,373)		\$ 468,873	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,715,985	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 77,343	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,177	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,166)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,318,312	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: _____

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: Annual Lease *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 3,535 Description: Ice Maker - \$900; Copier - \$2,139; Copier - \$496.

(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	Administrative	2002 Honda CR-V	\$ 490.00	\$ 5,881	17
18	Administrative	2002 Jeep Cherokee	500.00	6,000	18
19	Administrative	2002 Chevrolet	613.00	7,393	19
20	Administrative	2004 Honda Odyssey	343.00	3,492	20
21	TOTAL		\$ 1,603.00	\$ 22,766	21

10. Effective dates of current rental agreement:

Beginning 01/01/2004

Ending 12/31/2004

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

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* 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 NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED AIDES 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>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 AIDE _____</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 AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	39-2					33		33	13
14	TOTAL			\$		\$	33	\$	33	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning: 01/01/2004

Ending:

01/01/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/01/2004

(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	\$ 185,161	\$ 185,899	1
2	Cash-Patient Deposits	40,904	40,904	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	863,517	863,517	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,969	44,969	6
7	Other Prepaid Expenses	9,090	9,090	7
8	Accounts Receivable (owners or related parties)	40,276	40,276	8
9	Other(specify): <u>Investment in Hamlin</u>		651,752	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,183,917	\$ 1,836,407	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,000	13
14	Buildings, at Historical Cost		1,536,832	14
15	Leasehold Improvements, at Historical Cost	492,623	567,328	15
16	Equipment, at Historical Cost	540,006	540,006	16
17	Accumulated Depreciation (book methods)	(630,570)	(1,393,379)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deposits</u>	500	500	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 402,559	\$ 1,356,287	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,586,476	\$ 3,192,694	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 44,451	\$ 44,451	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,650	63,650	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		229,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17A</u>	1,609,163	1,609,163	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,717,264	\$ 1,946,264	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,717,264	\$ 1,946,264	46
47	TOTAL EQUITY(page 18, line 24)	\$ (130,788)	\$ 1,246,430	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,586,476	\$ 3,192,694	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (280,208)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (280,208)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	599,620	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	(450,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 149,420	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)	\$ (130,788)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,521,113	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,521,113	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	928	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 928	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	24,470	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,315	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 25,785	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	569	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 569	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,548,395	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	862,389	31
32	Health Care	1,150,958	32
33	General Administration	1,186,776	33
	B. Capital Expense		
34	Ownership	649,767	34
	C. Ancillary Expense		
35	Special Cost Centers	33	35
36	Provider Participation Fee	98,820	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,948,743	40
41	Income before Income Taxes (line 30 minus line 40)**	599,652	41
42	Income Taxes	(32)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 599,620	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** 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 Winston Manor Cnv & Nursing

0035782

Report Period Beginning: 01/01/2004

Ending: 01/01/2004

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	1,547	1,763	\$ 48,760	\$ 27.66	1
2	Assistant Director of Nursing	2,389	2,421	54,622	22.56	2
3	Registered Nurses	7,551	8,041	195,741	24.34	3
4	Licensed Practical Nurses	8,738	9,384	153,977	16.41	4
5	Nurse Aides & Orderlies	50,681	56,063	525,770	9.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,974	2,214	25,557	11.54	8
9	Activity Director	1,975	2,111	18,645	8.83	9
10	Activity Assistants	8,697	9,309	69,159	7.43	10
11	Social Service Workers	2,040	2,104	30,007	14.26	11
12	Dietician					12
13	Food Service Supervisor	2,583	2,799	35,410	12.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,986	21,180	171,893	8.12	15
16	Dishwashers					16
17	Maintenance Workers	966	990	9,523	9.62	17
18	Housekeepers	20,754	21,961	177,417	8.08	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	2,295	2,351	21,844	9.29	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,581	13,377	108,062	8.08	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)	143,757	156,068	\$ 1,646,387 *	\$ 10.55	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	\$ 8,880	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	1,580	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L	1,127	10A-3	40
41	Occupational Therapy Consultant	Y	258	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	3,463	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 15,308		49

C. CONTRACT NURSES

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

