

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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>0035782</u></p> <p>Facility Name: <u>Winston Manor Cnv & Nursing</u></p> <p>Address: <u>2155 West Pierce Avenue</u> <u>Chicago</u> <u>60622</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 252-2066</u> Fax # <u>(773) 252-3688</u></p> <p>HFS ID Number: <u>363671711001</u></p> <p>Date of Initial License for Current Owners: <u>01/01/1990</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> <p>In the event there are further questions about this report, please contact: Name: <u>Sanford B. Alper</u> Telephone Number: <u>(847) 580-4100</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	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>01/01/2007</u> to <u>12/31/2007</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2"></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td rowspan="6">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Sanford B. Alper</u> <u>Principal</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Kessler Orlean Silver & Company, P.C.</u> <u>1101 Lake Cook Road, Suite C, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 580-4100</u> Fax # <u>(847) 580-4199</u></td> </tr> <tr> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____	(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Sanford B. Alper</u> <u>Principal</u>	(Firm Name & Address) <u>Kessler Orlean Silver & Company, P.C.</u> <u>1101 Lake Cook Road, Suite C, IL 60015</u>	(Telephone) <u>(847) 580-4100</u> Fax # <u>(847) 580-4199</u>	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
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Facility Name & ID Number Winston Manor Cnv & Nursing

0035782 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	65,700	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	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					8
9	SNF/PED					9
10	ICF	58,429	425	797	59,651	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,429	425	797	59,651	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.79%

D. How many bed-hold days during this year were paid by the Department? 1,126 (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)

N/A

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 _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	208,645	27,898	9,576	246,119		246,119	12,978	259,097		1
2	Food Purchase		186,935		186,935	(27,571)	159,364	(332)	159,032		2
3	Housekeeping	213,230	14,956		228,186		228,186		228,186		3
4	Laundry		4,571	9,657	14,228		14,228		14,228		4
5	Heat and Other Utilities			115,836	115,836		115,836	1,852	117,688		5
6	Maintenance	26,044	31,713	54,991	112,748		112,748	25,659	138,407		6
7	Other (specify):* See Attached Sch			12,364	12,364		12,364		12,364		7
8	TOTAL General Services	447,919	266,073	202,424	916,416	(27,571)	888,845	40,157	929,002		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,067,072	22,397	5,434	1,094,903		1,094,903		1,094,903		10
10a	Therapy	29,745		580	30,325		30,325		30,325		10a
11	Activities	78,219	3,493		81,712		81,712		81,712		11
12	Social Services	54,828		6,456	61,284		61,284		61,284		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,229,864	25,890	12,470	1,268,224		1,268,224		1,268,224		16
	C. General Administration										
17	Administrative			379,890	379,890		379,890	(213,406)	166,484		17
18	Directors Fees										18
19	Professional Services			28,115	28,115		28,115	5,593	33,708		19
20	Dues, Fees, Subscriptions & Promotions			29,969	29,969		29,969	(13,480)	16,489		20
21	Clerical & General Office Expenses	258,834		51,316	310,150		310,150	106,046	416,196		21
22	Employee Benefits & Payroll Taxes			390,021	390,021	27,571	417,592	40,334	457,926		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,755	1,755		1,755	(380)	1,375		24
25	Other Admin. Staff Transportation		8,268		8,268		8,268	(4,086)	4,182		25
26	Insurance-Prop.Liab.Malpractice			145,553	145,553		145,553	441	145,994		26
27	Other (specify):* Bad Debts			9,929	9,929		9,929	(9,929)			27
28	TOTAL General Administration	258,834	8,268	1,036,548	1,303,650	27,571	1,331,221	(88,867)	1,242,354		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,936,617	300,231	1,251,442	3,488,290		3,488,290	(48,710)	3,439,580		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:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			21,828	21,828		21,828	54,247	76,075			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							199,596	199,596			33
34	Rent-Facility & Grounds			592,596	592,596		592,596	(592,596)				34
35	Rent-Equipment & Vehicles			22,759	22,759		22,759	449	23,208			35
36	Other (specify):*											36
37	TOTAL Ownership			637,183	637,183		637,183	(338,304)	298,879			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		613		613		613		613			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*							15,005	15,005			43
44	TOTAL Special Cost Centers		613	98,550	99,163		99,163	15,005	114,168			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,936,617	300,844	1,987,175	4,224,636		4,224,636	(372,009)	3,852,627			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 Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	2,823	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	(332)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(836)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12)	21		18
19	Entertainment				19
20	Contributions	(25,325)	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	(9,929)	27		24
25	Fund Raising, Advertising and Promotional	(3,980)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,292)	20		28
29	Other-Attach Schedule <u>See Attached Schedule</u>	(6,449)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,332)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(320,677)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (320,677)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (372,009)		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Franchise Tax	\$ (100)	21	1
2	Non-Deductible Dues	(2,301)	20	2
3	Franchise Tax - Management Company	(21)	21	3
4	Prepaid Seminar Costs	(380)	24	4
5	Travel expenses paid on behave of other faciliateis	(3,647)	25	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	(6,449)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	12,978	0	0	0	0	0	0	0	0	12,978	1
2	Food Purchase	(332)	0	0	0	0	0	0	0	0	0	0	(332)	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	1,852	0	0	0	0	0	0	0	0	0	1,852	5
6	Maintenance	0	803	24,856	0	0	0	0	0	0	0	0	25,659	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(332)	2,655	37,834	0	40,157	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	(213,406)	0	0	0	0	0	0	0	0	(213,406)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	5,593	0	0	0	0	0	0	0	0	5,593	19
20	Fees, Subscriptions & Promotions	(13,573)	93	0	0	0	0	0	0	0	0	0	(13,480)	20
21	Clerical & General Office Expenses	(25,458)	1,412	130,092	0	0	0	0	0	0	0	0	106,046	21
22	Employee Benefits & Payroll Taxes	0	40,334	0	0	0	0	0	0	0	0	0	40,334	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(380)	0	0	0	0	0	0	0	0	0	0	(380)	24
25	Other Admin. Staff Transportation	(4,483)	44	353	0	0	0	0	0	0	0	0	(4,086)	25
26	Insurance-Prop.Liab.Malpractice	0	441	0	0	0	0	0	0	0	0	0	441	26
27	Other (specify):*	(9,929)	0	0	0	0	0	0	0	0	0	0	(9,929)	27
28	TOTAL General Administration	(53,823)	42,324	(77,368)	0	(88,867)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,155)	44,979	(39,534)	0	(48,710)	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	2,823	0	51,424	0	0	0	0	0	0	0	0	54,247	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	199,596	0	0	0	0	0	0	0	0	199,596	33
34	Rent-Facility & Grounds	0	0	(592,596)	0	0	0	0	0	0	0	0	(592,596)	34
35	Rent-Equipment & Vehicles	0	449	0	0	0	0	0	0	0	0	0	449	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,823	449	(341,576)	0	0	0	0	0	0	0	0	(338,304)	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	15,005	0	0	0	0	0	0	0	0	15,005	43
44	TOTAL Special Cost Centers	0	0	15,005	0	0	0	0	0	0	0	0	15,005	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(51,332)	45,428	(366,105)	0	0	0	0	0	0	0	0	(372,009)	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	Central Home, Inc.	Chicago	Nivram Mng, Inc.	Lincolnwood	Management
Joseph Mermelstein	25.00	Balmoral Home, Inc.	Chicago			
		Chicago Ridge Nursing Center	Chicago Ridge	Pierce Building Ptsp	Chicago	Lessoer

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	21 Delivery Expense	\$	Nivram Management, Inc.	50.00%	\$ 273	\$ 273	1	
2	V	21 Office Expense		Nivram Management, Inc.	50.00%	866	866	2	
3	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	93	93	3	
4	V	21 Franchise Tax		Nivram Management, Inc.	50.00%	21	21	4	
5	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	38,314	38,314	5	
6	V	5 Utilities		Nivram Management, Inc.	50.00%	1,852	1,852	6	
7	V	26 Insurance		Nivram Management, Inc.	50.00%	441	441	7	
8	V	6 Repairs & Maintenance		Nivram Management, Inc.	50.00%	681	681	8	
9	V	22 Health Insurance		Nivram Management, Inc.	50.00%	2,020	2,020	9	
10	V	6 Scavenger		Nivram Management, Inc.	50.00%	122	122	10	
11	V	35 Rental Equipment		Nivram Management, Inc.	50.00%	449	449	11	
12	V	25 Auto Expense		Nivram Management, Inc.	50.00%	44	44	12	
13	V	21 Postage		Nivram Management, Inc.	50.00%	252	252	13	
14	Total		\$			\$ 45,428	\$ *	45,428	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	19 Legal and Accounting	\$	Nivram Management, Inc.	50.00%	\$ 5,593	\$	5,593	15
16	V	25 Travel		Nivram Management, Inc.	50.00%	353		353	16
17	V	21 Donations		Nivram Management, Inc.	50.00%	93		93	17
18	V	30 Depreciation		Nivram Management, Inc.	50.00%	519		519	18
19	V	21 Data Processing		Nivram Management, Inc.	50.00%	453		453	19
20	V	21 Telephone		Nivram Management, Inc.	50.00%	1,295		1,295	20
21	V	6 Plant Supervisor Salary		Nivram Management, Inc.	50.00%	24,856		24,856	21
22	V	17 Asst. Administrator Salary		Nivram Management, Inc.	50.00%	37,284		37,284	22
23	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	44,997		44,997	23
24	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	12,978		12,978	24
25	V	17 Administrative Salary		Nivram Management, Inc.	50.00%	55,703		55,703	25
26	V	17 Administrator Salary		Nivram Management, Inc.	50.00%	68,525		68,525	26
27	V	21 Clerical Salary		Nivram Management, Inc.	50.00%	81,813		81,813	27
28	V	17 Management Fees	374,918	Nivram Management, Inc.	50.00%			(374,918)	28
29	V								29
30	V	30 Depreciation		Pierce Building Partnership	50.00%	50,905		50,905	30
31	V	33 Real Estate Taxes		Pierce Building Partnership	50.00%	199,596		199,596	31
32	V	21 State Income Taxes		Pierce Building Partnership	50.00%	1,441		1,441	32
33	V	34 Rental Income	592,596	Pierce Building Partnership	50.00%			(592,596)	33
34	V	43 Loss from Hamlin Investments		Pierce Building Partnership	50.00%	15,005		15,005	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 967,514			\$ 601,409	\$ *	(366,105)	39

* 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:

01/01/2007

Ending:

12/31/2007

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	0.00	238,975	5	13.10	Salary	\$ 36,025	17-7	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	77,022	6	14.42	Salary	12,978	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	75.00	155,144	4	20.71	Salary	24,856	6-7	3
4	Doreen Mermelstein	Office Manager	Support	0.00	58,563	17	43.45	Salary	44,997	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	142,716	6	20.71	Salary	37,284	17-7	6
7	Joseph Mermelstein	Administrative	Administrative	25.00	75,322	2	20.71	Salary	19,678	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 175,818		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: 01/01/2007 Ending: 2/31/2007

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 Avenue
 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	Delivery Expense	Resident Beds	869	4	\$ 1,319	\$ 180	\$ 273	1	
2	21	Office Expense	Resident Beds	869	4	4,179	180	866	2	
3	20	Dues & Subscriptions	Resident Beds	869	4	450	180	93	3	
4	21	Franchise Tax	Resident Beds	869	4	100	180	21	4	
5	22	Payroll Tax	Resident Beds	869	4	184,970	180	38,314	5	
6	5	Utilities	Resident Beds	869	4	8,942	180	1,852	6	
7	26	Insurance	Resident Beds	869	4	2,128	180	441	7	
8	6	Repair & Maintenance	Resident Beds	869	4	3,286	180	681	8	
9	22	Health Insurance	Resident Beds	869	4	9,750	180	2,020	9	
10	6	Scavenger	Resident Beds	869	4	591	180	122	10	
11	35	Rental Equipment	Resident Beds	869	4	2,167	180	449	11	
12	25	Auto Expense	Resident Beds	869	4	214	180	44	12	
13	21	Postage	Resident Beds	869	4	1,217	180	252	13	
14	19	Legal & Accounting	Resident Beds	869	4	27,004	180	5,593	14	
15	25	Travel	Resident Beds	869	4	1,703	180	353	15	
16	21	Donations	Resident Beds	869	4	450	180	93	16	
17	30	Depreciation	Resident Beds	869	4	2,507	180	519	17	
18	21	Data Processing	Resident Beds	869	4	2,186	180	453	18	
19	21	Telephone	Resident Beds	869	4	6,252	180	1,295	19	
20	6	Plant Supervisor Salary	Direct Cost	1	1	24,856	24,856	1	24,856	20
21	17	Asst. Administrator	Direct Cost	1	1	37,284	37,284	1	37,284	21
22	21	Office Manager Salary	Direct Cost	1	1	44,997	44,997	1	44,997	22
23	1	Food Service Supervisor Salary	Direct Cost	1	1	12,978	12,978	1	12,978	23
24	17	Administrative Salary	Direct Cost	1	1	55,703	55,703	1	55,703	24
25	TOTALS					\$ 435,233	\$ 175,818	\$ 229,552	25	

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 Avenue
 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	\$ 68,525	\$ 68,525	1	\$ 68,525	1
2	21	Clerical Salary	Direct Cost	1	1	81,813	81,813	1	81,813	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					\$ 150,338	\$ 150,338		\$ 150,338	25

Facility Name & ID Number

Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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							\$	\$				\$						
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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winston Manor Cnv & Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035782

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-06-106-001-0000</u>	<u>Nursing Home</u>	\$ <u>212,595.51</u>	\$ <u>212,595.51</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>212,595.51</u>	\$ <u>212,595.51</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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

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, CNA 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:

01/01/2007 Ending: 12/31/2007

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	180	1989		\$ 1,536,832	\$ 48,781	31.5	\$ 48,781	\$	\$ 884,406	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Security System		1990	9,200	292	31.5	292		5,220	9
10	Interior Improvements		1990	32,039	1,018	31.5	1,018		17,853	10
11	Elevator		1990	5,300	168	31.5	168		2,933	11
12	Tiling & Lobby Office		1990	10,143	322	31.5	322		5,569	12
13	Building Improvements		1991	3,230	103	31.5	103		1,698	13
14	Building Improvements		1991	4,806	153	31.5	153		2,511	14
15	Tiles		1991	11,906	377	31.5	377		6,064	15
16	Radiator Cover		1992	12,400	394	31.5	394		6,222	16
17	Electrical Work		1992	3,500	111	31.5	111		1,744	17
18	Building Improvements		1993	21,476	550	39	550		7,916	18
19	Building Improvements		1995	34,754	891	39	891		6,175	19
20	Flooring & Tile		1996	5,355	137	39	137		1,581	20
21	Generator		1996	35,589	913	39	913		10,538	21
22	Air Conditioner		1996	16,511	423	39	423		4,883	22
23	Alarm System		1996	3,744	96	39	96		1,108	23
24	Roof		1996	1,200	31	39	31		358	24
25	Hot Water Heater		1996	2,900	74	39	74		854	25
26	Smoke Eater		1993	4,600		10			4,600	26
27	Air Conditioner		1993	2,550		10			2,550	27
28	Carpet		1993	3,527		10			3,527	28
29	Boiler		1993	3,600		10			3,600	29
30	Air Conditioner		1994	5,122		10			5,122	30
31	Hot Water Heater		1995	4,160		10			4,160	31
32	Air Conditioner		1995	2,816		10			2,816	32
33	Glass		1995	647		10	7	7	647	33
34	Roof		1997	21,350	547	39	547		5,744	34
35	Phone System		1997	13,666	350	39	350		3,675	35
36										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:

01/01/2007 Ending: 12/31/2007

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	Electrical Work	1997	\$ 49,685	\$ 1,274	39	\$ 1,274	\$	\$ 13,377	37
38	Central Air Conditioning	1997	35,499	910	39	910		9,555	38
39	New Office Construction	1997	4,442	114	39	114		1,197	39
40	Boiler Insulation / Insulation	1997	29,412	755	39	755		8,015	40
41	Fire Alarm & Sprinklers	1997	2,475	64	39	64		674	41
42	Doors & Construction	1997	8,190	210	39	210		2,205	42
43	Plumbing - Toilets, Pipes	1997	4,719	121	39	121		1,271	43
44	Roof	1998	3,900	100	39	100		950	44
45	HVAC Work	1998	2,700	69	39	69		656	45
46	Doors & Construction	1998	2,729	70	39	70		665	46
47	Time Clock	1998	5,244	135	39	135		1,157	47
48	Air Conditioner	1998	777	20	39	20		190	48
49	Phone System	1998	1,283	33	39	33		289	49
50	Door	1999	2,500	64	39	64		481	50
51	Fire Damper	1999	1,783	46	39	46		345	51
52	Water System	1999	6,000	154	39	154		1,155	52
53	Door Construction	1999	2,500	64	39	64		448	53
54	Kitchen and Tiling	1999	10,250	263	39	263		1,972	54
55	New Windows	2001	1,300	33	39	33		199	55
56	Doors & Fram	2001	2,025	53	39	53		317	56
57	Electric Wiring	2001	443	11	39	11		67	57
58	Wall Repair	2001	1,000	26	39	26		156	58
59	Roof Repair	2003	1,150	15	39	15		103	59
60	Brick Paver	2004	40,000	1,026	39	1,026		4,104	60
61	Tuckpointing	2004	23,518	603	39	603		2,412	61
62	Bulding Improvements from Building Partnership	1995	74,705	2,122	39	2,122		31,112	62
63	Bathroom Remodeling	2005	5,125	131	39	131		295	63
64	Pump	2005	2,600	67	39	67		173	64
65	Water Heater	2005	7,400	190	39	190		396	65
66	Elevator Machine Room	2006	41,767	1,071	39	1,071		1,071	66
67	Boiler	2006	32,500	833	39	833		972	67
68	Symmetry Construction	2006	5,500	141	39	141		176	68
69	Kitchen Fire Safety System	2006	1,600	41	39	41		44	69
70	TOTAL (lines 4 thru 69)		\$ 2,227,644	\$ 66,560		\$ 66,567	\$ 7	\$ 1,090,273	70

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

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,227,644	\$ 66,560		\$ 66,567	\$ 7	\$ 1,090,273	1
2	Elevator Recall System	2006	4,500	115	39	115		115	2
3	Wireless Temperature Control	2006	3,500	90	39	90		97	3
4	Pushbutton Lock	2006	380	10	39	10		11	4
5	Roof	2006	7,100	182	39	182		182	5
6	Boiler	2007	26,890	517	39	689	172	689	6
7	Elevator Equipment	2007	8,171	105	39	210	105	210	7
8	Power Flame Gas Burner	2007	7,000	22	39	179	157	179	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	TOTAL (lines 1 thru 33)		\$ 2,285,185	\$ 67,601		\$ 68,042	\$ 441	\$ 1,091,756	34

**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	\$ 46,715	\$ 2,290	\$ 4,672	\$ 2,382	10	\$ 45,323	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	401,108				10	401,108	73
74	Mgmt Co & Bldg Ptrnshp		2,643	2,643		10	6,939	74
75	TOTALS	\$ 447,823	\$ 4,933	\$ 7,315	\$ 2,382		\$ 453,370	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2001 Ford Taurus	2006	\$ 2,245	\$ 718	\$ 718	\$	5	\$ 898	76
77										77
78										78
79										79
80	TOTALS			\$ 2,245	\$ 718	\$ 718	\$		\$ 898	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)	\$ 2,840,253	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 73,252	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,075	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,823	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,546,024	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: \$ 3,337 Description: Ice Maker - \$900; Copier - \$2,437

(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>See Attached Schedule</u>			<u>19,422</u>	18
19					19
20					20
21	TOTAL		\$	\$ <u>19,422</u>	21

10. Effective dates of current rental agreement:

Beginning 01/01/2007

Ending 12/31/2007

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

Fiscal Year Ending Annual Rent

12. /2008 \$ _____

13. /2009 \$ _____

14. /2010 \$ _____

* 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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					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): Respiratory	39-2					613		613	13
14	TOTAL			\$		\$	613	\$	613	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.

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 261,617	\$ 262,355	1
2	Cash-Patient Deposits	10,135	10,135	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	929,270	929,270	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,589	110,589	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	39,112	38,011	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,350,723	\$ 1,350,360	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	646,655	721,360	15
16	Equipment, at Historical Cost	551,760	551,760	16
17	Accumulated Depreciation (book methods)	(690,349)	(1,605,866)	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):		588,172	22
23	Other(specify): <u>Deposits</u>	500	500	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 508,566	\$ 1,897,758	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,859,289	\$ 3,248,118	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 24,732	\$ 24,732	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,387	9,387	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,725	123,725	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		219,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,500	11,941	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	2,675,292	2,675,292	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,843,636	\$ 3,064,077	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)	\$ 2,843,636	\$ 3,064,077	46
47	TOTAL EQUITY(page 18, line 24)	\$ (984,347)	\$ 184,041	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,859,289	\$ 3,248,118	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (460,904)	1
2	Restatements (describe):		2
3	Adjustment	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (460,902)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,019,119	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	(1,542,564)	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)	\$ (523,445)	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)	\$ (984,347)	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	\$ 5,208,171	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,208,171	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,547	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,547	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	2,687	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,687	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,327	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,327	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Commissions</u>	3,500	28
28a	<u>Miscellaneous Income</u>	17,225	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,725	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,254,457	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	916,416	31
32	Health Care	1,268,224	32
33	General Administration	1,303,650	33
	B. Capital Expense		
34	Ownership	637,183	34
	C. Ancillary Expense		
35	Special Cost Centers	613	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,224,636	40
41	Income before Income Taxes (line 30 minus line 40)**	1,029,821	41
42	Income Taxes	(10,702)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,019,119	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:

01/01/2007

Ending:

12/31/2007

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	1,698	1,754	\$ 57,197	\$ 32.61	1
2	Assistant Director of Nursing	2,235	2,291	58,899	25.71	2
3	Registered Nurses	11,587	12,204	262,580	21.52	3
4	Licensed Practical Nurses	3,388	3,653	64,741	17.72	4
5	CNAs & Orderlies	53,987	60,060	623,655	10.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,924	2,148	29,745	13.85	8
9	Activity Director	1,819	2,036	21,233	10.43	9
10	Activity Assistants	6,137	6,685	56,986	8.52	10
11	Social Service Workers	5,581	5,809	54,828	9.44	11
12	Dietician					12
13	Food Service Supervisor	1,937	2,153	37,169	17.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,862	17,622	171,476	9.73	15
16	Dishwashers					16
17	Maintenance Workers	1,878	2,094	26,044	12.44	17
18	Housekeepers	21,188	22,602	213,230	9.43	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,693	15,811	258,834	16.37	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)	143,914	156,922	\$ 1,936,617 *	\$ 12.34	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	\$ 9,576	1-3	35
36	Medical Director	O	3,000	10-3	36
37	Medical Records Consultant	N	1,940	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	494	10-3	39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y	580	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	6,456	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,046		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	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 60,260	IDPH License Fee	\$	
				Unemployment Compensation Insurance	25,688	Advertising: Employee Recruitment	3,980	
				FICA Taxes	147,268	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	135,534	Patient Background Checks	138 1,000	
				Employee Meals	27,571	Yellow Pagens Advertising	7,292	
				Illinois Municipal Retirement Fund (IMRF)*		See Attached Schedule	15,396	
				Union Pension	19,041	Allocation from Management Compay	93	
				Other Employee Benefits	2,230			
				Allocation from Management Company	40,334			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(3,980)	
Description			Amount			Yellow page advertising	(7,292)	
Management Fees			\$ 379,890					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 379,890	TOTAL (agree to Schedule V, line 22, col.8)	\$ 457,926	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,489	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Kessler, Orlean, Silver & Co.	Accounting		\$ 15,225				Out-of-State Travel	\$
Michael Jarecki	Legal		1,750					
Automatic Data System, Inc.	Payroll Service		2,561					
Accu-Med Services, Inc.	Computer		2,695				In-State Travel	
Health Data Systems, Inc.	Computer		1,879					
Medifax-Edi, LLC	Computer		651					
Personnel Planners, Inc.	U/C Consultant		3,354				Seminar Expense	1,375
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 28,115	TOTAL			Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,375

* Attach copy of IMRF notifications

**See instructions.

