

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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> Email Address: _____</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>01/01/2008</u> to <u>12/31/2008</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: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Sanford B. Alper</u> <u>Principal</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Kessler Orlean Silver and Company, P.C.</u> <u>1101 Lake Cook Rd, Ste C, Deerfield 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847)580-4100</u> Fax # <u>(847)580-4199</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) <u>Sanford B. Alper</u> <u>Principal</u>		(Firm Name & Address) <u>Kessler Orlean Silver and Company, P.C.</u> <u>1101 Lake Cook Rd, Ste C, Deerfield 60015</u>		(Telephone) <u>(847)580-4100</u> Fax # <u>(847)580-4199</u>
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Facility Name & ID Number Winston Manor Cnv & Nursing

0035782 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	60,116	126		60,242	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,116	126		60,242	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.44%

D. How many bed-hold days during this year were paid by the Department?

966 (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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	234,749	17,765	9,816	262,330		262,330	14,276	276,606		1
2	Food Purchase		208,635		208,635	(30,241)	178,394	(541)	177,853		2
3	Housekeeping	224,380	31,936		256,316		256,316		256,316		3
4	Laundry		5,089		5,089		5,089		5,089		4
5	Heat and Other Utilities			128,299	128,299		128,299	3,230	131,529		5
6	Maintenance	28,355	29,851	13,131	71,337		71,337	28,961	100,298		6
7	Other (specify):*			14,989	14,989		14,989		14,989		7
8	TOTAL General Services	487,484	293,276	166,235	946,995	(30,241)	916,754	45,926	962,680		8
	B. Health Care and Programs										
9	Medical Director			2,750	2,750		2,750		2,750		9
10	Nursing and Medical Records	1,112,361	25,980	73,122	1,211,463		1,211,463		1,211,463		10
10a	Therapy	31,513			31,513		31,513		31,513		10a
11	Activities	78,221	3,146	1,943	83,310		83,310		83,310		11
12	Social Services	148,132	258	6,224	154,614		154,614		154,614		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,370,227	29,384	84,039	1,483,650		1,483,650		1,483,650		16
	C. General Administration										
17	Administrative	31,076		395,182	426,258		426,258	177,352	603,610		17
18	Directors Fees										18
19	Professional Services			38,778	38,778		38,778	4,971	43,749		19
20	Dues, Fees, Subscriptions & Promotions			27,002	27,002	410	27,412	(10,563)	16,849		20
21	Clerical & General Office Expenses	123,984		68,870	192,854	(410)	192,444	97,615	290,059		21
22	Employee Benefits & Payroll Taxes			382,275	382,275	30,241	412,516	29,730	442,246		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,250	1,250		1,250	380	1,630		24
25	Other Admin. Staff Transportation			9,223	9,223		9,223	(1,292)	7,931		25
26	Insurance-Prop.Liab.Malpractice			113,497	113,497		113,497	361	113,858		26
27	Other (specify):* Bad Debts			24,275	24,275		24,275	(24,275)			27
28	TOTAL General Administration	155,060		1,060,352	1,215,412	30,241	1,245,653	274,279	1,519,932		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,012,771	322,660	1,310,626	3,646,057		3,646,057	320,205	3,966,262		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:

01/01/2008

Ending:

12/31/2008

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			20,831	20,831		20,831	51,113	71,944			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							201,326	201,326			33
34	Rent-Facility & Grounds			590,326	590,326		590,326	(590,326)				34
35	Rent-Equipment & Vehicles			24,301	24,301		24,301	368	24,669			35
36	Other (specify):*											36
37	TOTAL Ownership			635,458	635,458		635,458	(337,519)	297,939			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28		28		28		28			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):*							32,439	32,439			43
44	TOTAL Special Cost Centers		28	98,820	98,848		98,848	32,439	131,287			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,012,771	322,688	2,044,904	4,380,363		4,380,363	15,125	4,395,488			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	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	56	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	(541)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,330)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(540)	21		18
19	Entertainment				19
20	Contributions	(37,950)	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	(24,275)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,000)	20		28
29	Other-Attach Schedule	(8,020)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (75,600)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(304,457)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (304,457)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (380,057)		37

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

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

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

Winston Manor Cnv & Nursing

ID# 0035782

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Franchise Tax	\$ (100)	21	1
2	Non-Deductible Dues	(6,702)	20	2
3	Franchise Tax - Management Company	(21)	21	3
4	Seminar Costs Prepaid in 2007	380	24	4
5	Chicago Head Tax paid for Affiliated Company	(1,092)	20	5
6	Resident Background Checks Paid for Affiliates	(590)	21	6
7	Worker Background Checks Paid by Affiliates	105	20	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	(8,020)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	14,276	0	0	0	0	0	0	0	0	14,276	1
2	Food Purchase	(541)	0	0	0	0	0	0	0	0	0	0	(541)	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	3,230	0	0	0	0	0	0	0	0	0	3,230	5
6	Maintenance	0	1,619	27,342	0	0	0	0	0	0	0	0	28,961	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(541)	4,849	41,618	0	45,926	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	177,352	0	0	0	0	0	0	0	0	177,352	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	4,971	0	0	0	0	0	0	0	0	4,971	19
20	Fees, Subscriptions & Promotions	(10,689)	95	31	0	0	0	0	0	0	0	0	(10,563)	20
21	Clerical & General Office Expenses	(39,201)	1,804	135,012	0	0	0	0	0	0	0	0	97,615	21
22	Employee Benefits & Payroll Taxes	0	29,730	0	0	0	0	0	0	0	0	0	29,730	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	(1,330)	38	0	0	0	0	0	0	0	0	0	(1,292)	25
26	Insurance-Prop.Liab.Malpractice	0	361	0	0	0	0	0	0	0	0	0	361	26
27	Other (specify):*	(24,275)	0	0	0	0	0	0	0	0	0	0	(24,275)	27
28	TOTAL General Administration	(75,115)	32,028	317,366	0	274,279	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(75,656)	36,877	358,984	0	320,205	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	56	0	51,057	0	0	0	0	0	0	0	0	51,113	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	201,326	0	0	0	0	0	0	0	0	201,326	33
34	Rent-Facility & Grounds	0	0	(590,326)	0	0	0	0	0	0	0	0	(590,326)	34
35	Rent-Equipment & Vehicles	0	368	0	0	0	0	0	0	0	0	0	368	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	56	368	(337,943)	0	0	0	0	0	0	0	0	(337,519)	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	32,439	0	0	0	0	0	0	0	0	32,439	43
44	TOTAL Special Cost Centers	0	0	32,439	0	0	0	0	0	0	0	0	32,439	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(75,600)	37,245	53,480	0	0	0	0	0	0	0	0	15,125	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	75.70	Central Home, Inc.	Chicago	Nivram Mnmgt, Inc	Lincolnwood	Management
Joseph Mermelstein	24.30	Balmoral Home, Inc.	Chicago			
		Chicago Ridge Nursing Center	Chicago Ridge	Pierce Bldg Partnrsp	Lincolnwood	Lessor

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%	\$ 457	\$	457	1
2	V	21 Office Expense		Nivram Management, Inc.	50.00%	884		884	2
3	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	95		95	3
4	V	21 Franchise Tax		Nivram Management, Inc.	50.00%	21		21	4
5	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	27,143		27,143	5
6	V	5 Utilities		Nivram Management, Inc.	50.00%	3,230		3,230	6
7	V	26 Insurance		Nivram Management, Inc.	50.00%	361		361	7
8	V	6 Repairs & Maintenance		Nivram Management, Inc.	50.00%	1,508		1,508	8
9	V	22 Health Insurance		Nivram Management, Inc.	50.00%	2,587		2,587	9
10	V	6 Scavenger		Nivram Management, Inc.	50.00%	111		111	10
11	V	35 Equipment Rental		Nivram Management, Inc.	50.00%	368		368	11
12	V	25 Auto Expense		Nivram Management, Inc.	50.00%	38		38	12
13	V	21 Postage		Nivram Management, Inc.	50.00%	442		442	13
14	Total		\$			\$ 37,245	\$ *	37,245	14

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

Facility Name & ID Number Winston Manor Cnv & Nursing# 0035782Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 & Accounting	\$	Nivram Management, Inc.	50.00%	\$ 4,971	\$ 4,971
16	V	20 Licenses & Permits		Nivram Management, Inc.	50.00%	31	31
17	V	30 Depreciation		Nivram Management, Inc.	50.00%	154	154
18	V	21 Data Processing		Nivram Management, Inc.	50.00%	491	491
19	V	21 Telephone		Nivram Management, Inc.	50.00%	1,612	1,612
20	V	6 Plant Supervisor Salary		Nivram Management, Inc.	50.00%	27,342	27,342
21	V	17 Asst. Administrator Salary		Nivram Management, Inc.	50.00%	41,013	41,013
22	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	49,490	49,490
23	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	14,276	14,276
24	V	17 Administrative Salaries		Nivram Management, Inc.	50.00%	61,274	61,274
25	V	17 Administrator Salary		Nivram Management, Inc.	50.00%	75,065	75,065
26	V	21 Clerical Salaries		Nivram Management, Inc.	50.00%	82,220	82,220
27	V	Management Fees	395,182	Nivram Management, Inc.	50.00%		(395,182)
28	V						
29	V	30 Depreciation		Pierce Building Partnership	50.00%	50,903	50,903
30	V	33 Real Estate Taxes		Pierce Building Partnership	50.00%	201,326	201,326
31	V	21 State Income Taxes		Pierce Building Partnership	50.00%	1,199	1,199
32	V	34 Rental Income	590,326	Pierce Building Partnership	50.00%		(590,326)
33	V	43 Loss from Hamlin Investments		Pierce Building Partnership	50.00%	32,439	32,439
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 985,508			\$ 643,806	\$ * (341,702)

* 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:

01/01/2008

Ending:

12/31/2008

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	262,872	5	13.10	Salary	\$ 39,628	17-7	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	84,724	6	14.42	Salary	14,276	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	75.70	104,658	4	20.71	Salary	27,342	6-7	3
4	Doreen Mermelstein	Office Manager	Support	0.00	64,410	17	43.45	Salary	49,490	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	156,987	6	20.71	Salary	41,013	17-7	6
7	Joseph Mermelstein	Administrative	Administrative	24.30	82,854	2	20.71	Salary	21,646	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 193,395		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:

01/01/2008

Ending: 2/31/2008

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	\$ 2,205	\$ 180	\$ 457	1	
2	21	Office Expense	Resident Beds	869	4	4,269	180	884	2	
3	20	Dues & Subscriptions	Resident Beds	869	4	460	180	95	3	
4	21	Franchise Tax	Resident Beds	869	4	100	180	21	4	
5	22	Payroll Taxes	Resident Beds	869	4	131,039	180	27,143	5	
6	5	Utilities	Resident Beds	869	4	15,594	180	3,230	6	
7	26	Insurance	Resident Beds	869	4	1,745	180	361	7	
8	6	Repairs & Maintenance	Resident Beds	869	4	7,278	180	1,508	8	
9	22	Health Insurance	Resident Beds	869	4	12,490	180	2,587	9	
10	6	Scavenger	Resident Beds	869	4	538	180	111	10	
11	35	Equipment Rental	Resident Beds	869	4	1,777	180	368	11	
12	25	Auto Expense	Resident Beds	869	4	183	180	38	12	
13	21	Postage	Resident Beds	869	4	2,133	180	442	13	
14	19	Legal & Accounting	Resident Beds	869	4	24,000	180	4,971	14	
15	20	Licenses & Permits	Resident Beds	869	4	150	180	31	15	
16	30	Depreciation	Resident Beds	869	4	743	180	154	16	
17	21	Data Processing	Resident Beds	869	4	2,369	180	491	17	
18	21	Telephone	Resident Beds	869	4	7,780	180	1,612	18	
19	6	Plant Supervisor Salary	Direct Cost	1	1	27,342	27,342	1	27,342	19
20	17	Asst. Administrtor Salary	Direct Cost	1	1	41,013	41,013	1	41,013	20
21	21	Office Manager Salary	Direct Cost	1	1	49,490	49,490	1	49,490	21
22	1	Food Service Supervisor Salary	Direct Cost	1	1	14,276	14,276	1	14,276	22
23	17	Administrative Salaries	Direct Cost	1	1	61,274	61,274	1	61,274	23
24		Administrator Salary	Direct Cost	1	1	75,065	75,065	1	75,065	24
25	TOTALS					\$ 483,313	\$ 268,460	\$ 312,964	25	

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical Salaries	1	1	\$ 82,220	\$ 82,220	1	\$ 82,220	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 82,220	\$ 82,220		\$ 82,220	25

Facility Name & ID Number

Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6	Parkway Bank & Trust Co.		X	Working Capital	Interest only	01/08	152,500		01/09	Variable	778	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 152,500	\$			\$ 778	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13	Interest Income										(778)	13						
14	TOTAL Non-Facility Related						\$	\$			\$ (778)	14						
15	TOTALS (line 9+line14)						\$ 152,500	\$			\$	15						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.		\$	219,000	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.)		\$	210,326	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(8,674)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	210,000	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.		\$	201,326	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	217,673	8
	2004	222,509	9
	2005	224,774	10
	2006	212,596	11
	2007	210,326	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>210,325.86</u>	\$ <u>210,325.86</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>210,325.86</u>	\$ <u>210,325.86</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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:

01/01/2008 Ending: 12/31/2008

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	\$ 48,782	31.5	\$ 48,782	\$	\$ 933,188	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Security System		1990	9,200	292	31.5	292		5,512	9
10	Interior Improvements		1990	32,039	1,018	31.5	1,018		18,871	10
11	Elevator		1990	5,300	168	31.5	168		3,101	11
12	Tiling & Lobby Office		1990	10,143	322	31.5	322		5,891	12
13	Building Improvements		1991	3,230	103	31.5	103		1,801	13
14	Building Improvements		1991	4,806	153	31.5	153		2,664	14
15	Tiles		1991	11,906	377	31.5	377		6,441	15
16	Radiator Cover		1992	12,400	394	31.5	394		6,616	16
17	Electrical Work		1992	3,500	111	31.5	111		1,855	17
18	Building Improvements		1993	21,476	550	39	550		8,466	18
19	Building Improvements		1995	34,754	891	39	891		12,067	19
20	Flooring & Tile		1996	5,355	137	39	137		1,718	20
21	Generator		1996	35,589	913	39	913		11,451	21
22	Air Conditioner		1996	16,511	423	39	423		5,306	22
23	Alarm System		1996	3,744	96	39	96		1,204	23
24	Roof		1996	1,200	31	39	31		389	24
25	Hot Water Heater		1996	2,900	74	39	74		928	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			647	33
34	Roof		1997	21,350	547	39	547		6,500	34
35	Phone System		1997	13,666	350	39	350		4,131	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:

01/01/2008 Ending: 12/31/2008

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	\$	\$ 14,811	37
38	Central Air Conditioning	1997	35,499	910	39	910		10,582	38
39	New Office Construction	1997	4,442	114	39	114		1,324	39
40	Boiler Insulation	1997	29,412	755	39	755		8,767	40
41	Fire Alarm & Sprinklers	1997	2,475	64	39	64		736	41
42	Doors & Construction	1997	8,190	210	39	210		2,371	42
43	Plumbing - Toilets & Pipes	1997	4,719	121	39	121		1,376	43
44	Roof	1998	3,900	100	39	100		1,088	44
45	HVAC Work	1998	2,700	69	39	69		747	45
46	Doors & Construction	1998	2,729	70	39	70		715	46
47	Time Clock	1998	5,244	135	39	135		1,416	47
48	Air Conditioner	1998	777	20	39	20		210	48
49	Phone System	1998	1,283	33	39	33		352	49
50	Door	1999	2,500	64	39	64		590	50
51	Fire Damper	1999	1,783	46	39	46		425	51
52	Water System	1999	6,000	154	39	154		1,404	52
53	Door Construction	1999	2,500	64	39	64		590	53
54	Kitchen and Tiling	1999	10,250	263	39	263		2,574	54
55	New Windows	2001	1,300	33	39	33		232	55
56	Doors & Frame	2001	2,025	53	39	53		370	56
57	Electric Wiring	2001	443	11	39	11		78	57
58	Wall Repair	2001	1,000	26	39	26		182	58
59	Roof Repair	2003	1,150	15	39	15		654	59
60	Brick Paver	2004	40,000	1,026	39	1,026		4,274	60
61	Tuckpointing	2004	23,518	603	39	603		2,663	61
62	Building Improvement from Building Partnership	1995	74,705	2,121	39	2,121		33,232	62
63	Bathroom Remodeling	2005	5,125	131	39	131		427	63
64	Pump	2005	2,600	67	39	67		239	64
65	Water Heater	2005	7,400	190	39	190		585	65
66	Elevator Machine Room	2006	41,767	1,071	39	1,071		2,142	66
67	Boiler Insulation	2006	32,500	833	39	833		1,806	67
68	Symmetry Construction	2006	5,500	141	39	141		317	68
69	Kitchen Fire Safety System	2006	1,600	41	39	41		85	69
70	TOTAL (lines 4 thru 69)		\$ 2,227,644	\$ 66,560		\$ 66,560	\$	\$ 1,162,486	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	
	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		\$ 66,560	\$	\$ 1,162,486	1
2	Elevator Recall System	2006	4,500	116	39	116		231	2
3	Wireless Temperature Control	2006	3,500	90	39	90		187	3
4	Pushbutton Lock	2006	380	9	39	9		20	4
5	Roof	2006	7,100	182	39	182		364	5
6	Boiler	2007	26,890	690	39	690		1,207	6
7	Elevator Equipment	2007	8,171	209	39	209		314	7
8	Power Flame Gas Burner	2007	7,000	180	39	180		202	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	\$ 68,036		\$ 68,036	\$	\$ 1,165,011	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	\$ 30,485	\$ 3,242	\$ 3,049	\$ (193)	10	\$ 27,401	71
72	Current Year Purchases	500	25	25		10	25	72
73	Fully Depreciated Assets	492,037				10	484,602	73
74	Management Company		154	609	455	10		74
75	TOTALS	\$ 523,022	\$ 3,421	\$ 3,683	\$ 262		\$ 512,028	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	\$ 431	\$ 225	\$ (206)	5	\$ 561	76
77										77
78										78
79										79
80	TOTALS			\$ 2,245	\$ 431	\$ 225	\$ (206)		\$ 561	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)	\$ 2,915,452	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,888	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 71,944	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 56	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,677,600	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: \$ 3,309 Description: Ice Maker - \$900; Copier - \$2,409

(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	See Schedule Attached			20,992	18
19					19
20					20
21	TOTAL		\$	\$ 20,992	21

10. Effective dates of current rental agreement:

Beginning 01/01/2008

Ending 12/31/2008

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

Fiscal Year Ending Annual Rent

12. /2009 \$ _____

13. /2010 \$ _____

14. /2011 \$ _____

* 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	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	Other (specify): _____									12
13	Other (specify): <u>Respiratory</u>	<u>39-2</u>					<u>28</u>		<u>28</u>	13
14	TOTAL			\$		\$	<u>28</u>	\$	<u>28</u>	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: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 85,269	\$ 85,406	1
2	Cash-Patient Deposits	28,564	28,564	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,778,404	1,778,404	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,559	55,559	6
7	Other Prepaid Expenses	180	180	7
8	Accounts Receivable (owners or related parties)	39,952	38,011	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,987,928	\$ 1,986,124	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	552,260	552,260	16
17	Accumulated Depreciation (book methods)	(711,180)	(1,677,600)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Invstmt in Partnshp</u>)		555,733	22
23	Other(specify): <u>Deposit</u>	500	500	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 488,235	\$ 1,794,085	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,476,163	\$ 3,780,209	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 50,500	\$ 50,500	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,871	25,871	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,796	64,796	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		210,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,394	8,593	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	3,227,902	3,227,902	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,376,463	\$ 3,587,662	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)	\$ 3,376,463	\$ 3,587,662	46
47	TOTAL EQUITY(page 18, line 24)	\$ (900,128)	\$ 192,719	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,476,335	\$ 3,780,381	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (984,347)	1
2	Restatements (describe):		2
3	Reflect increase in dividends	(44,435)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,028,782)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,378,654	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	(1,250,000)	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)	\$ 128,654	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)	\$ (900,128)	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	\$ 5,705,486	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,705,486	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	869	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 869	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	1,639	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,639	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	27,936	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,936	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending commissions	2,625	28
28a	Miscellaneous	28,184	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,809	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,766,739	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	946,995	31
32	Health Care	1,483,650	32
33	General Administration	1,215,412	33
B. Capital Expense			
34	Ownership	635,286	34
C. Ancillary Expense			
35	Special Cost Centers	28	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)*	\$ 4,380,191	40
41	Income before Income Taxes (line 30 minus line 40)**	1,386,548	41
42	Income Taxes	(7,894)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,378,654	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:

01/01/2008

Ending:

12/31/2008

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	1,628	1,851	\$ 63,248	\$ 34.17	1
2	Assistant Director of Nursing	2,763	2,970	75,662	25.48	2
3	Registered Nurses	15,943	16,577	328,087	19.79	3
4	Licensed Practical Nurses	2,434	2,613	46,116	17.65	4
5	CNAs & Orderlies	50,891	56,730	594,660	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,929	2,263	31,513	13.93	8
9	Activity Director	1,909	2,133	23,185	10.87	9
10	Activity Assistants	6,372	6,739	55,036	8.17	10
11	Social Service Workers	7,851	8,310	148,132	17.83	11
12	Dietician					12
13	Food Service Supervisor	2,034	2,258	39,386	17.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,637	20,551	195,363	9.51	15
16	Dishwashers					16
17	Maintenance Workers	1,991	2,127	28,355	13.33	17
18	Housekeepers	22,213	24,061	224,380	9.33	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	1,600	1,688	31,076	18.41	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,179	10,110	123,984	12.26	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	549	574	4,588	7.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,923	161,555	\$ 2,012,771 *	\$ 12.46	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			35	
36	Medical Director	M	2,750	9-3	36
37	Medical Records Consultant	O	1,366	10-3	37
38	Nurse Consultant	N F			38
39	Pharmacist Consultant	T E			39
40	Physical Therapy Consultant	H E			40
41	Occupational Therapy Consultant	L			41
42	Respiratory Therapy Consultant	Y			42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	1,943	11-3	44
45	Social Service Consultant	104	6,224	13-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	137	\$ 12,283		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,999	\$ 71,756	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,999	\$ 71,756		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	
Annette Betancur	Asst Administ	0	\$ 31,076	Workers' Compensation Insurance	\$ 40,096	IDPH License Fee	\$	
				Unemployment Compensation Insurance	19,757	Advertising: Employee Recruitment	2,093	
				FICA Taxes	157,972	Health Care Worker Background Check		
				Employee Health Insurance	139,781	(Indicate # of checks performed (15))	105	
				Employee Meals	30,241	Patient Background Checks	41	
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Pages Advertising	3,000	
				Head Tax	4,728	See Attached Schedule	11,915	
				Union Pension	19,941	Allocation from Management Company	126	
				Allocation from Management Company	29,730	Chicago Long Term Care License	2,200	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 31,076					
B. Administrative - Other								
Description			Amount					
Management Fees			\$ 395,182			Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	(3,000)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 395,182	TOTAL (agree to Schedule V, line 22, col.8)	\$ 442,246	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,849	
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		\$ 14,850			\$	Out-of-State Travel	\$
Manher Shah-Khan	Legal		1,500					
Eugene Callahan & Associates	Legal		57					
Automatic Data Processing	Payroll Service		2,413				In-State Travel	
Accu-Med Services, Inc.	Computer		5,890					
Health Data Systems, Inc.	Computer		2,460					
Medifax-EDI, LLC	Computer		777					
E-Health Data Solutions	Medicare/Medicaid Consltnt		6,456				Seminar Expense	1,630
IL Assoc of Health Care Facilities	Union Negotiations		2,160					
Personnel Planners, Inc.	U/C Consultant		1,880					
Anthony's Fingerprinting	Fingerprinting		335				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 38,778	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,630

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
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