

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	60,374	795	(191)	60,978	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,374	795		60,978	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.81%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	242,394	15,271	9,974	267,639		267,639	27,071	294,710		1
2	Food Purchase		265,787		265,787	(30,223)	235,564	(43)	235,521		2
3	Housekeeping	208,328	32,552		240,880		240,880		240,880		3
4	Laundry		9,211		9,211		9,211		9,211		4
5	Heat and Other Utilities			89,041	89,041		89,041	4,535	93,576		5
6	Maintenance	63,310	31,207		94,517		94,517	56,661	151,178		6
7	Other (specify):* Attached Schedule			23,117	23,117		23,117	138	23,255		7
8	TOTAL General Services	514,032	354,028	122,132	990,192	(30,223)	959,969	88,362	1,048,331		8
	B. Health Care and Programs										
9	Medical Director			2,750	2,750		2,750		2,750		9
10	Nursing and Medical Records	1,271,222	44,300	155,561	1,471,083		1,471,083		1,471,083		10
10a	Therapy	230		4,382	4,612		4,612		4,612		10a
11	Activities	87,267	1,545		88,812		88,812		88,812		11
12	Social Services	206,863		4,093	210,956		210,956		210,956		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,565,582	45,845	166,786	1,778,213		1,778,213		1,778,213		16
	C. General Administration										
17	Administrative			568,020	568,020		568,020	(298,936)	269,084		17
18	Directors Fees										18
19	Professional Services			55,311	55,311		55,311	3,621	58,932		19
20	Dues, Fees, Subscriptions & Promotions			5,928	5,928		5,928	2,766	8,694		20
21	Clerical & General Office Expenses	65,436		100,262	165,698		165,698	58,310	224,008		21
22	Employee Benefits & Payroll Taxes			426,488	426,488	30,223	456,711	53,752	510,463		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,490	3,490		3,490		3,490		24
25	Other Admin. Staff Transportation			10,629	10,629		10,629	(1,493)	9,136		25
26	Insurance-Prop.Liab.Malpractice			86,946	86,946		86,946	1,235	88,181		26
27	Other (specify):*										27
28	TOTAL General Administration	65,436		1,257,074	1,322,510	30,223	1,352,733	(180,745)	1,171,988		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,145,050	399,873	1,545,992	4,090,915		4,090,915	(92,383)	3,998,532		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:

01/01/2013

Ending:

12/31/2013

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			20,693	20,693		20,693	66,939	87,632			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			184	184		184	(184)				32
33	Real Estate Taxes							241,037	241,037			33
34	Rent-Facility & Grounds			495,324	495,324		495,324	(495,324)				34
35	Rent-Equipment & Vehicles			26,927	26,927		26,927	17	26,944			35
36	Other (specify):*											36
37	TOTAL Ownership			543,128	543,128		543,128	(187,515)	355,613			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			10	10		10		10			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			468,782	468,782		468,782		468,782			42
43	Other (specify):*							7,177	7,177			43
44	TOTAL Special Cost Centers			468,792	468,792		468,792	7,177	475,969			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,145,050	399,873	2,557,912	5,102,835		5,102,835	(272,721)	4,830,114			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:

01/01/2013

Ending:

12/31/2013**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	8,701	30		9
10	Interest and Other Investment Income	(189)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(259)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(1,699)	25		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(31,800)	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	(43,745)	21		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				28
29	Other-Attach Schedule	(988)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,979)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(680,454)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (680,454)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (750,433)		37

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

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

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

BHF USE ONLY

48		49		50		51		52	
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Winston Manor Cnv & Nursing

ID# 0035782

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Trust Fees	\$ (150)	21	1
2	Franchise Tax	(838)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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	(988)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	27,071	0	0	0	0	0	0	0	0	27,071	1
2	Food Purchase	(259)	0	216	0	0	0	0	0	0	0	0	(43)	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	4,535	0	0	0	0	0	0	0	0	0	4,535	5
6	Maintenance	0	1,276	55,385	0	0	0	0	0	0	0	0	56,661	6
7	Other (specify):*	0	138	0	0	0	0	0	0	0	0	0	138	7
8	TOTAL General Services	(259)	5,949	82,672	0	0	0	0	0	0	0	0	88,362	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	(484,942)	186,006	0	0	0	0	0	0	0	(298,936)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,621	0	0	0	0	0	0	0	0	3,621	19
20	Fees, Subscriptions & Promotions	0	2,556	210	0	0	0	0	0	0	0	0	2,766	20
21	Clerical & General Office Expenses	(76,533)	3,504	45,923	85,416	0	0	0	0	0	0	0	58,310	21
22	Employee Benefits & Payroll Taxes	0	53,752	0	0	0	0	0	0	0	0	0	53,752	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,699)	36	170	0	0	0	0	0	0	0	0	(1,493)	25
26	Insurance-Prop.Liab.Malpractice	0	1,235	0	0	0	0	0	0	0	0	0	1,235	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(78,232)	61,083	(435,018)	271,422	0	(180,745)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(78,491)	67,032	(352,346)	271,422	0	(92,383)	29						

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	8,701	0	58,238	0	0	0	0	0	0	0	0	66,939	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(189)	5	0	0	0	0	0	0	0	0	0	(184)	32
33	Real Estate Taxes	0	0	241,037	0	0	0	0	0	0	0	0	241,037	33
34	Rent-Facility & Grounds	0	17,308	(512,632)	0	0	0	0	0	0	0	0	(495,324)	34
35	Rent-Equipment & Vehicles	0	17	0	0	0	0	0	0	0	0	0	17	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	8,512	17,330	(213,357)	0	0	0	0	0	0	0	0	(187,515)	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	7,177	0	0	0	0	0	0	0	0	7,177	43
44	TOTAL Special Cost Centers	0	0	7,177	0	0	0	0	0	0	0	0	7,177	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(69,979)	84,362	(558,526)	271,422	0	(272,721)	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	75.70	Balmoral Home, Inc.	Chicago	Nivram Mngt, Inc.	Lincolnwood	Management
Joseph Mermelstein	24.30	Chicago Ridge Nursing Center	Chicago Ridge	Pierce Bldg Partner	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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	25 Auto Expense	\$	Nivram Management, Inc.	50.00%	\$ 36	\$	36	1
2	V	6 Repairs & Maintenance		Nivram Management, Inc.	50.00%	1,276		1,276	2
3	V	5 Utilities		Nivram Management, Inc.	50.00%	4,535		4,535	3
4	V	21 Office Expense		Nivram Management, Inc.	50.00%	3,467		3,467	4
5	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	2,556		2,556	5
6	V	21 Taxes - Other		Nivram Management, Inc.	50.00%	37		37	6
7	V	32 Interest Expense		Nivram Management, Inc.	50.00%	5		5	7
8	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	39,985		39,985	8
9	V	34 Rent		Nivram Management, Inc.	50.00%	17,308		17,308	9
10	V	26 Insurance		Nivram Management, Inc.	50.00%	1,235		1,235	10
11	V	22 Health Insurance		Nivram Management, Inc.	50.00%	13,767		13,767	11
12	V	7 Scavenger		Nivram Management, Inc.	50.00%	138		138	12
13	V	35 Rental Equipment		Nivram Management, Inc.	50.00%	17		17	13
14	Total		\$			\$ 84,362	\$ *	84,362	14

* 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:

01/01/2013

Ending:

12/31/2013

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	2 Sales Taxes	\$	Nivram Management, Inc.	50.00%	\$ 216	\$	216	15
16	V	21 Postage		Nivram Management, Inc.	50.00%	589		589	16
17	V	19 Legal & Accounting		Nivram Management, Inc.	50.00%	1,128		1,128	17
18	V	20 Licenses & Permits		Nivram Management, Inc.	50.00%	210		210	18
19	V	25 Travel		Nivram Management, Inc.	50.00%	170		170	19
20	V	30 Depreciation		Nivram Management, Inc.	50.00%	987		987	20
21	V	21 Data Processing		Nivram Management, Inc.	50.00%	832		832	21
22	V	21 Telephone		Nivram Management, Inc.	50.00%	1,810		1,810	22
23	V	21 Donations		Nivram Management, Inc.	50.00%	3		3	23
24	V	17 Management Fees	568,020	Nivram Management, Inc.				(568,020)	24
25	V	34 Rental Income	495,324	Pierce Building Partnership				(495,324)	25
26	V	43 Loss from Investments		Pierce Building Partnership		7,177		7,177	26
27	V	30 Depreciation		Pierce Building Partnership		50,898		50,898	27
28	V	33 Real Estate Taxes		Pierce Building Partnership		232,324		232,324	28
29	V	21 State Income Taxes		Pierce Building Partnership		1,853		1,853	29
30	V	34 Rental Income	17,308	Hamlin & Arthur Partnership				(17,308)	30
31	V	21 Bank Fees		Hamlin & Arthur Partnership		80		80	31
32	V	30 Depreciation		Hamlin & Arthur Partnership		6,353		6,353	32
33	V	19 Legal Fees		Hamlin & Arthur Partnership		2,493		2,493	33
34	V	33 Real Estate Taxes		Hamlin & Arthur Partnership		8,713		8,713	34
35	V	6 Plant Supervisor Salary		Nivram Management, Inc.	50.00%	55,385		55,385	35
36	V	17 Asst. Administrator		Nivram Management, Inc.	50.00%	83,078		83,078	36
37	V	21 Officer Manager Salary		Nivram Management, Inc.	50.00%	40,756		40,756	37
38	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	27,071		27,071	38
39	Total		\$ 1,080,652			\$ 522,126	\$ *	(558,526)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 Administrative Salaries	\$	Nivram Management, Inc.	50.00%	\$ 104,968	\$	104,968	15
16	V	17 Administrator Salary		Nivram Management, Inc.	50.00%	81,038		81,038	16
17	V	21 Clerical Salaries		Nivram Management, Inc.	50.00%	85,416		85,416	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 271,422	\$ *	271,422	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: 01/01/2013 Ending: 12/31/2013

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	166,667	13	33.33	Salary	\$ 83,333	17-7	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	54,142	6	31.58	Salary	27,071	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	75.70	136,617	5	28.85	Salary	55,385	6-7	3
4	Doreen Mermelstein	Office Manager	Support	0.00	81,512	13	33.33	Salary	40,756	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	204,926	8	28.85	Salary	83,078	17-7	6
7	Joseph Mermelstein	Administrative	Administrative	24.30	53,365	3	28.85	Salary	21,635	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 311,258		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:

01/01/2013Ending: 2/31/2013

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	25	Auto Expense	Resident Beds	624	3	\$ 126	\$ 180	\$ 36	1	
2	6	Repairs & Maitenance	Resident Beds	624	3	4,422	180	1,276	2	
3	5	Utilities	Resident Beds	624	3	15,718	180	4,534	3	
4	21	Donations	Resident Beds	624	3	10	180	3	4	
5	21	Office Expense	Resident Beds	624	3	12,020	180	3,467	5	
6	20	Dues & Subscriptions	Resident Beds	624	3	8,861	180	2,556	6	
7	21	Taxes - Other	Resident Beds	624	3	128	180	37	7	
8	32	Interest Expense	Resident Beds	624	3	19	180	5	8	
9	22	Payroll Taxes	Resident Beds	624	3	138,615	180	39,985	9	
10	34	Rent	Resident Beds	624	3	60,000	180	17,308	10	
11	26	Insurance	Resident Beds	624	3	4,282	180	1,235	11	
12	22	Health Insurance	Resident Beds	624	3	47,724	180	13,767	12	
13	7	Scavenger	Resident Beds	624	3	480	180	138	13	
14	35	Rental Equipment	Resident Beds	624	3	60	180	17	14	
15	2	Sales Taxes	Resident Beds	624	3	749	180	216	15	
16	21	Postage	Resident Beds	624	3	2,042	180	589	16	
17	19	Legal & Accounting	Resident Beds	624	3	3,911	180	1,128	17	
18	20	Licenses & Permits	Resident Beds	624	3	729	180	210	18	
19	25	Travel	Resident Beds	624	3	590	180	170	19	
20	30	Depreciation	Resident Beds	624	3	3,422	180	987	20	
21	21	Data Processing	Resident Beds	624	3	2,884	180	832	21	
22	21	Telephone	Resident Beds	624	3	6,274	180	1,810	22	
23	6	Plant Supervisor Salary	Direct Cost	624	1	55,385	55,385	180	15,976	23
24	17	Asst. Administrator Salary	Direct Cost	624	1	83,078	83,078	180	23,965	24
25	TOTALS					\$ 451,529	\$ 138,463	\$ 130,247	25	

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

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	Office Manager Salary	Direct Cost	1	\$ 40,756	\$ 40,756	1	\$ 40,756	1
2	1	Food Service Supervisor Salary	Direct Cost	1	27,071	27,071	1	27,071	2
3	17	Administrative Salaries	Direct Cost	1	104,968	104,968	1	104,968	3
4	17	Administrator Salary	Direct Cost	1	81,038	81,038	1	81,038	4
5	21	Clerical Salaries	Direct Cost	1	85,416	85,416	1	85,416	5
6	21	Bank Fees	Resident Beds	624	280		180	81	6
7	30	Depreciation Expense	Resident Beds	624	22,025		180	6,353	7
8	19	Legal Fees	Resident Beds	624	8,643		180	2,493	8
9	33	Real Estate Taxes	Resident Beds	624	30,203		180	8,712	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				\$ 400,400	\$ 339,249		\$ 356,888	25

Facility Name & ID Number

Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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		X	Line of Credit	n/a	12/01/12	104,815		06/01/2014	0.0325	184	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 104,815	\$			\$ 184	9						
B. Non-Facility Related*																		
10	Citi Credit Card		X	Financing	n/a	n/a	n/a	n/a	n/a	n/a	5	10						
11	Offset Interest Income										(189)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (184)	14						
15	TOTALS (line 9+line14)						\$ 104,815	\$			\$	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 2012 report.			\$	<u>204,000</u>	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.)			\$	<u>224,037</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>20,037</u>	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>221,000</u>	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.			\$	<u>241,037</u>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>212,436</u>			8
	2009	<u>190,141</u>			9
	2010	<u>198,419</u>			10
	2011	<u>230,843</u>			11
	2012	<u>250,242</u>			12
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2012	\$		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.

2012 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 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-06-106-001-0000</u>	<u>Nursing Home</u>	\$ <u>215,324.28</u>	\$ <u>215,324.28</u>
2. <u>10-35-325-015-0000</u>	<u>Management Company</u>	\$ <u>31,097.53</u>	\$ <u>7,715.00</u>
3. <u>10-35-325-015-0000</u>	<u>Management Company</u>	\$ <u>4,022.75</u>	\$ <u>998.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>250,444.56</u></u>	\$ <u><u>224,037.28</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

01/01/2013 Ending:

12/31/2013

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).

N/A

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.

Table with 6 columns: Line Item, Use, Square Feet, Year Acquired, Cost, and another column. Row 1: 1, Nursing Home, 1989, \$105,000, 1. Row 2: 2, 2. Row 3: 3, TOTALS, \$105,000, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	180	1989		\$ 1,536,832	\$ 48,776	31.5	\$ 48,776	\$	\$ 1,177,100	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Security System	1990		9,200	292	31.5	292		6,972	9
10	Interior Improvements	1990		32,039	1,018	31.5	1,018		23,961	10
11	Elevator	1990		5,300	168	31.5	168		3,941	11
12	Tiling & Lobby Office	1990		10,143	321	31.5	321		7,496	12
13	Building Improvements	1991		3,230	103	31.5	103		2,316	13
14	Building Improvements	1991		4,806	153	31.5	153		3,429	14
15	Tiles	1991		11,906	377	31.5	377		8,326	15
16	Radiator Cover	1992		12,400	394	31.5	394		8,586	16
17	Electrical Work	1992		3,500	111	31.5	111		2,410	17
18	Building Improvements	1993		21,476	550	39	550		11,218	18
19	Building Improvements	1995		34,754	891	39	891		16,522	19
20	Flooring & Tile	1996		5,355	138	39	138		2,406	20
21	Generator	1996		35,589	913	39	913		16,014	21
22	Air Conditioner	1996		16,511	423	39	423		7,421	22
23	Alarm System	1996		3,744	96	39	96		1,684	23
24	Roof	1996		1,200	31	39	31		544	24
25	Hot Water Heater	1996		2,900	74	39	74		1,298	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		9,237	34
35	Phone System	1997		13,666	351	39	351		5,884	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Electrical Work	1997	\$ 49,685	\$ 1,274	39	\$ 1,274	\$	\$ 21,181	37
38	Central Air Conditioning	1997	35,499	910	39	910		15,132	38
39	New Office Construction	1997	4,442	114	39	114		1,894	39
40	Boiler Insulation	1997	29,412	754	39	754		12,537	40
41	Fire Alarm & Sprinkler	1997	2,475	63	39	63		1,054	41
42	Doors & Construction	1997	8,190	210	39	210		3,421	42
43	Plumbing - Toilets & Pipes	1997	4,719	121	39	121		1,981	43
44	Roof	1998	3,900	100	39	100		1,588	44
45	HVAC Work	1998	2,700	69	39	69		1,092	45
46	Doors & Construction	1998	2,729	69	39	69		1,063	46
47	Time Clock	1998	5,245	135	39	135		2,091	47
48	Air Conditioner	1998	777	20	39	20		310	48
49	Phone System	1998	1,283	33	39	33		517	49
50	Door	1999	2,500	64	39	64		910	50
51	Fire Damper	1999	1,783	45	39	45		655	51
52	Water System	1999	6,000	154	39	154		2,174	52
53	Door Construction	1999	2,500	64	39	64		910	53
54	Kitchen and Tiling	1999	10,250	262	39	262		3,886	54
55	New Windows	2001	1,300	33	39	33		397	55
56	Doors & Frame	2001	2,025	53	39	53		635	56
57	Electric Wiring	2001	443	11	39	11		133	57
58	Wall Repair	2001	1,000	26	39	26		312	58
59	Roof Repair	2003	1,150	15	39	15		729	59
60	Brick Paver	2004	40,000	1,026	39	1,026		9,402	60
61	Tuckpointing	2004	23,518	603	39	603		5,678	61
62	Building Improvement from Building Partnership	1995	74,705	2,118	39	2,118		43,831	62
63	Bathroom Remodeling	2005	5,125	132	39	132		1,084	63
64	Pump	2005	2,600	66	39	66		571	64
65	Water Heater	2005	7,400	190	39	190		1,535	65
66	Elevator Machine Room	2006	41,767	1,071	39	1,071		7,497	66
67	Boiler Insulation	2006	32,500	833	39	833		5,971	67
68	Symmetry Construction	2006	5,500	141	39	141		1,022	68
69	Kitchen Fire Safety System	2006	1,600	41	39	41		292	69
70	TOTAL (lines 4 thru 69)		\$ 2,227,645	\$ 66,547		\$ 66,547	\$	\$ 1,495,272	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,227,645	\$ 66,547		\$ 66,547	\$	\$ 1,495,272	1
2	Elevator Recall System	2006	4,500	116	39	116		809	2
3	Wireless Temperature Control	2006	3,500	89	39	89		634	3
4	Pushbutton Lock	2006	380	10	39	10		70	4
5	Roof	2006	7,100	182	39	182		1,274	5
6	Boiler	2007	26,890	690	39	690		4,655	6
7	Elevator Equipment	2007	8,171	209	39	209		1,362	7
8	Power Flame Gas Burner	2007	7,000	180	39	180		1,100	8
9	Fire Alarm	2012	4,300	110	39	110		138	9
10	Doors Project	2012	3,978	102	39	102		128	10
11	Elevator Improvements	2012	9,000	230	39	230		288	11
12	Water Heater	2013	5,100		39				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)		\$ 2,307,564	\$ 68,465		\$ 68,465	\$	\$ 1,505,730	34

**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:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 44,474	\$	\$ 8,894	\$ 8,894	5-7	\$ 41,563	71
72	Current Year Purchases	4,054	1,004	811	(193)	5	811	72
73	Fully Depreciated Assets	515,448					515,448	73
74	<u>Mng Company & Bld Partn</u>		9,462	9,462				74
75	TOTALS	\$ 563,976	\$ 10,466	\$ 19,167	\$ 8,701		\$ 557,822	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	<u>Facility</u>	<u>001 Ford Taurus</u>	<u>2006</u>	\$ 2,245	\$	\$	\$	5	\$ 2,245	76
77										77
78										78
79										79
80	TOTALS			\$ 2,245	\$	\$	\$		\$ 2,245	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)	\$ 2,978,785	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 78,931	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 87,632	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,701	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,065,797	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: Pierce Building Partnership

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: \$ 2,741 Description: Copier - \$1,824; Ice Maker - \$900 Copier - Mng Company - \$17

(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>24,203</u>	18
19					19
20					20
21	TOTAL		\$	\$ 24,203	21

10. Effective dates of current rental agreement:

Beginning 01/01/2013

Ending 12/31/2013

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

Fiscal Year Ending Annual Rent

12. /2014 \$ _____

13. /2015 \$ _____

14. /2016 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2013**

(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	\$ 382,268	\$ 382,489	1
2	Cash-Patient Deposits	24,965	24,965	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,308,015	1,308,015	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,947	57,947	6
7	Other Prepaid Expenses	24,350	24,350	7
8	Accounts Receivable (owners or related parties)		449,832	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,797,545	\$ 2,247,598	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	669,033	743,738	15
16	Equipment, at Historical Cost	566,218	566,218	16
17	Accumulated Depreciation (book methods)	(821,875)	(2,042,812)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Deposits</u>)	500	500	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 413,876	\$ 909,476	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,211,421	\$ 3,157,074	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 67,426	\$ 67,426	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,965	24,965	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,404	53,404	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		221,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	17,058	18,911	35
	Other Current Liabilities(specify):			
36	<u>Attached Schedule</u>	3,483,315	3,483,315	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,646,168	\$ 3,869,021	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)	\$ 3,646,168	\$ 3,869,021	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,434,747)	\$ (711,947)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,211,421	\$ 3,157,074	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,421,156)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,421,155)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	986,408	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	()	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)	\$ 986,408	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)	\$ (1,434,747)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,996,765	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,996,765	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	111,976	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 111,976	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	3,500	28
28a	<u>Miscellaneous Income</u>	2,057	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,557	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,114,298	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	990,192	31
32	Health Care	1,778,213	32
33	General Administration	1,322,510	33
B. Capital Expense			
34	Ownership	543,128	34
C. Ancillary Expense			
35	Special Cost Centers	10	35
36	Provider Participation Fee	468,782	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,102,835	40
41	Income before Income Taxes (line 30 minus line 40)**	1,011,463	41
42	Income Taxes	(25,055)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 986,408	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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: 01/01/2013

Ending: 12/31/2013

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	1,675	1,891	\$ 70,135	\$ 37.09	1
2	Assistant Director of Nursing	1,348	1,436	40,076	27.91	2
3	Registered Nurses	19,450	21,619	519,628	24.04	3
4	Licensed Practical Nurses	268	296	4,961	16.76	4
5	CNAs & Orderlies	47,134	56,777	636,422	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	15	15	230	15.33	8
9	Activity Director	1,940	2,156	25,815	11.97	9
10	Activity Assistants	6,249	6,687	61,452	9.19	10
11	Social Service Workers	13,530	14,194	206,863	14.57	11
12	Dietician					12
13	Food Service Supervisor	1,982	2,198	41,142	18.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,300	20,238	201,252	9.94	15
16	Dishwashers					16
17	Maintenance Workers	4,219	4,433	63,310	14.28	17
18	Housekeepers	17,497	20,272	208,328	10.28	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,642	7,096	65,436	9.22	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)	139,249	159,308	\$ 2,145,050 *	\$ 13.46	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	M	\$ 9,974	1-3	35
36	Medical Director	O	2,750	9-3	36
37	Medical Records Consultant	N	2,208	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	10,462	10-3	39
40	Physical Therapy Consultant	L	4,382	10a-3	40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	4,093	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,869		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6,572	\$ 142,891	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6,572	\$ 142,891		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	\$ 56,685	IDPH License Fee	\$		
				Unemployment Compensation Insurance	39,173	Advertising: Employee Recruitment	1,567		
				FICA Taxes	164,087	Health Care Worker Background Check (Indicate # of checks performed)			
				Employee Health Insurance	156,135	Patient Background Checks	55		
				Employee Meals	30,223	Attached Schedule	3,811		
				Illinois Municipal Retirement Fund (IMRF)*		Allocation from Management Company	2,766		
				Union Pension	10,062				
				Chicago Head Tax	346				
				Allocation from Management Company	53,752				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$						
B. Administrative - Other									
Description			Amount						
Management Fees			\$ 568,020						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 568,020	TOTAL (agree to Schedule V, line 22, col.8)			\$ 510,463		
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		\$ 32,822			\$	Out-of-State Travel	\$	
Brown, Udell, Pomerantz & Del	Legal		1,826						
Personnel Planners, Inc.	U/C Consultant		825						
Legat Architect	Architect		1,864				In-State Travel		
ATT	Computer		375						
Accu-Med Services, Inc.	Computer		3,840						
Automatic Data Processing	Computer		3,169						
Health Data System	Computer		3,729				Seminar Expense	3,490	
E Health Solutions	Computer		5,712						
Medifax-EDI, LLC	Computer		225						
Dell	Computer		424						
KBC Computer	Computer		500				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 55,311	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 3,490

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winston Manor Cnv & Nursing# 0035782Report Period Beginning: 01/01/2013Ending: 12/31/2013**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 468,782
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 30,223 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees