FOR BHF USE

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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.

I. IDPH License ID Number: 0035782

Facility Name: Winston Manor Cnv & Nursing

Address: 2155 West Pierce (Number) Chicago (City) 60622 (Zip Code)

County: Cook

Telephone Number: (773) 252-2066 **Fax #** (773) 252-3688

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford B Alper **Telephone Number:** (847) 580-4100
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Sanford B Alper, Principal
(Firm Name & Address) Kessler Orlean Silver & Company, P.C., 1101 Lake Cook Rd, Sute C, Deerfield IL 60015
(Telephone) (847) 580-4100 Fax # (847) 580-4199

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

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	57,931	86	(215)	57,802	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,931	86		57,802	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.98%

D. How many bed-hold days during this year were paid by the Department?
456 (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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 1989 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	228,087	17,118	9,816	255,021		255,021	363,748	618,769			1
2	Food Purchase		213,820		213,820	(19,991)	193,829	(9)	193,820			2
3	Housekeeping	202,869	26,211		229,080		229,080		229,080			3
4	Laundry		6,935		6,935		6,935		6,935			4
5	Heat and Other Utilities			96,783	96,783		96,783	3,981	100,764			5
6	Maintenance	65,527	36,889		102,416		102,416	90,444	192,860			6
7	Other (specify):* Attached Schedule			17,389	17,389		17,389	150	17,539			7
8	TOTAL General Services	496,483	300,973	123,988	921,444	(19,991)	901,453	458,314	1,359,767			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,027,768	29,731	331,704	1,389,203		1,389,203		1,389,203			10
10a	Therapy	31,983			31,983		31,983		31,983			10a
11	Activities	61,451	2,924		64,375		64,375		64,375			11
12	Social Services	133,034		9,180	142,214		142,214		142,214			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* MDS Coordinator	62,727			62,727		62,727		62,727			15
16	TOTAL Health Care and Programs	1,316,963	32,655	343,884	1,693,502		1,693,502		1,693,502			16
	C. General Administration											
17	Administrative	16,479		940,814	957,293		957,293	(647,921)	309,372			17
18	Directors Fees											18
19	Professional Services			68,041	68,041		68,041	(5,360)	62,681			19
20	Dues, Fees, Subscriptions & Promotions			28,900	28,900		28,900	(6,792)	22,108			20
21	Clerical & General Office Expenses	56,416		63,850	120,266		120,266	97,703	217,969			21
22	Employee Benefits & Payroll Taxes			408,829	408,829	19,991	428,820	52,969	481,789			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,410	1,410		1,410		1,410			24
25	Other Admin. Staff Transportation			6,168	6,168		6,168	(694)	5,474			25
26	Insurance-Prop.Liab.Malpractice			85,965	85,965		85,965	465	86,430			26
27	Other (specify):*											27
28	TOTAL General Administration	72,895		1,603,977	1,676,872	19,991	1,696,863	(509,630)	1,187,233			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,886,341	333,628	2,071,849	4,291,818		4,291,818	(51,316)	4,240,502			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: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,176	23,176		23,176	55,389	78,565			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							173,141	173,141			33
34	Rent-Facility & Grounds			570,141	570,141		570,141	(570,141)				34
35	Rent-Equipment & Vehicles			24,087	24,087		24,087	551	24,638			35
36	Other (specify):*											36
37	TOTAL Ownership			617,404	617,404		617,404	(341,060)	276,344			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127		127		127		127			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):* Loss Inv Hamlin Ptrshp											43
44	TOTAL Special Cost Centers		127	98,550	98,677		98,677		98,677			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,886,341	333,755	2,787,803	5,007,899		5,007,899	(392,376)	4,615,523			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: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	3,747	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	(130)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(987)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(740)	21		18
19	Entertainment				19
20	Contributions	(31,664)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,140)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,095)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,066)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(450)	20		28
29	Other-Attach Schedule	(43,833)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (85,358)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 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)	(307,018)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (307,018)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (392,376)		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 Yes	2 No	3 Amount	4 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: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Deductible Dues	$ (6,544)	20	1
2	Franchise Tax	(100)	21	2
3	Franchise Tax- Management Company	(29)	21	3
4	Trust Fee	(150)	21	4
5	Loss on Investment in Hamlin Partnership	(37,010)	43	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**	(43,833)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	363,748	0	0	0	0	0	0	0	0	363,748	1
2	Food Purchase	(130)	0	121	0	0	0	0	0	0	0	0	(9)	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	3,981	0	0	0	0	0	0	0	0	0	3,981	5
6	Maintenance	0	2,157	88,287	0	0	0	0	0	0	0	0	90,444	6
7	Other (specify):*	0	0	150	0	0	0	0	0	0	0	0	150	7
8	**TOTAL General Services**	(130)	6,138	452,306	0	0	0	0	0	0	0	0	458,314	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	(647,921)	0	0	0	0	0	0	0	0	(647,921)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,140)	0	780	0	0	0	0	0	0	0	0	(5,360)	19
20	Fees, Subscriptions & Promotions	(6,994)	159	43	0	0	0	0	0	0	0	0	(6,792)	20
21	Clerical & General Office Expenses	(37,844)	2,772	132,775	0	0	0	0	0	0	0	0	97,703	21
22	Employee Benefits & Payroll Taxes	0	52,969	0	0	0	0	0	0	0	0	0	52,969	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	(987)	219	74	0	0	0	0	0	0	0	0	(694)	25
26	Insurance-Prop.Liab.Malpractice	0	465	0	0	0	0	0	0	0	0	0	465	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(51,965)	56,584	(514,249)	0	0	0	0	0	0	0	0	(509,630)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(52,095)	62,722	(61,943)	0	0	0	0	0	0	0	0	(51,316)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Winston Manor Cnv & Nursing** **#** **0035782** **Report Period Beginning:** **01/01/2010** **Ending:** **12/31/2010**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,747	0	51,642	0	0	0	0	0	0	0	0	55,389	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	173,141	0	0	0	0	0	0	0	0	173,141	33
34	Rent-Facility & Grounds	0	0	(570,141)	0	0	0	0	0	0	0	0	(570,141)	34
35	Rent-Equipment & Vehicles	0	0	551	0	0	0	0	0	0	0	0	551	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,747	0	(344,807)	0	0	0	0	0	0	0	0	(341,060)	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):*	(37,010)	0	37,010	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(37,010)	0	37,010	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(85,358)	62,722	(369,740)	0	0	0	0	0	0	0	0	(392,376)	45

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Balmoral Home, Inc.	Chicago	Nivram Mngt, Inc.	Lincolnwood	Mangement
Joseph Mermelstein	24.30	Chicago Ridge Nursing Center	Chicago Ridge	Pierce Bldg Partnr	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. [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	25	Auto Expense	$	Nivram Management, Inc.	50.00%	$ 219	$ 219	1
2	V	21	Bank Charges		Nivram Management, Inc.	50.00%	5	5	2
3	V	6	Repairs and Maintenance		Nivram Management, Inc.	50.00%	2,157	2,157	3
4	V	5	Utilities		Nivram Management, Inc.	50.00%	3,981	3,981	4
5	V	21	Delivery Expense		Nivram Management, Inc.	50.00%	233	233	5
6	V	21	Donations		Nivram Management, Inc.	50.00%	14	14	6
7	V	21	Office Expenses		Nivram Management, Inc.	50.00%	2,375	2,375	7
8	V	20	Dues and Subscriptions		Nivram Management, Inc.	50.00%	159	159	8
9	V	21	Entertainment & Meals		Nivram Management, Inc.	50.00%	116	116	9
10	V	21	Franchise Tax		Nivram Management, Inc.	50.00%	29	29	10
11	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	35,434	35,434	11
12	V	26	Insurance		Nivram Management, Inc.	50.00%	465	465	12
13	V	22	Health Insurance		Nivram Management, Inc.	50.00%	17,535	17,535	13
14	Total			$			$ 62,722	$ * 62,722	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: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	Scavenger	$	Nivram Management, Inc.	50.00%	$ 150	$ 150	15
16	V	35	Equipment Rental		Nivram Management, Inc.	50.00%	551	551	16
17	V	2	Sales Taxes		Nivram Management, Inc.	50.00%	121	121	17
18	V	21	Postage		Nivram Management, Inc.	50.00%	413	413	18
19	V	19	Legal & Accounting		Nivram Management, Inc.	50.00%	780	780	19
20	V	20	Licenses & Permits		Nivram Management, Inc.	50.00%	43	43	20
21	V	25	Travel		Nivram Management, Inc.	50.00%	74	74	21
22	V	30	Depreciation		Nivram Management, Inc.	50.00%	736	736	22
23	V	21	Data Processing		Nivram Management, Inc.	50.00%	408	408	23
24	V	21	Telephone		Nivram Management, Inc.	50.00%	2,789	2,789	24
25	V	6	Plant Supervisor Salary		Nivram Management, Inc.	50.00%	88,287	88,287	25
26	V	17	Asst. Administrator		Nivram Management, Inc.	50.00%	132,430	132,430	26
27	V	21	Office Manager Salary		Nivram Management, Inc.	50.00%	38,187	38,187	27
28	V	1	Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	363,748	363,748	28
29	V	17	Administrative Salaries		Nivram Management, Inc.	50.00%	85,094	85,094	29
30	V	17	Administrator Salary		Nivram Management, Inc.	50.00%	75,369	75,369	30
31	V	21	Clerical Salaries		Nivram Management, Inc.	50.00%	88,912	88,912	31
32	V	17	Management Fees	940,814	Nivram Management, Inc.	50.00%		(940,814)	32
33	V								33
34	V	43	Loss from Hamlin Investments		Pierce Building Partnership		37,010	37,010	34
35	V	30	Depreciation		Pierce Building Partnership		50,906	50,906	35
36	V	33	Real Estate Taxes		Pierce Building Partnership		173,141	173,141	36
37	V	21	State Income Taxes		Pierce Building Partnership		2,066	2,066	37
38	V	34	Rental Income	570,141				(570,141)	38
39	Total			$ 1,510,955			$ 1,141,215	$ * (369,740)	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: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	0.00	123,333	13	33.33	Salary	$ 61,667	17-7	1
2	Louise Mermelsein	Dietary Supervisor	Support	0.00	727,497	6	31.58	Salary	363,748	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	75.70	217,774	5	28.85	Salary	88,287	6-7	3
4	Doreen Mermelstein	Office Manager	Support	0.00	76,373	13	33.33	Salary	38,187	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	326,661	8	28.85	Salary	132,430	17-7	6
7	Joseph Mermelstein	Administrative	Administrative	24.30	57,786	3	28.85	Salary	23,427	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 707,746		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: 01/01/2010 Ending: 2/31/2010

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 [X] 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	25	Auto Expense	Resident Beds	624	3	$ 758	$	180	$ 219	1
2	21	Bank Charges	Resident Beds	624	3	19		180	5	2
3	6	Repairs & Maintenance	Resident Beds	624	3	7,479		180	2,157	3
4	5	Utilities	Resident Beds	624	3	13,801		180	3,981	4
5	21	Delivery Expense	Resident Beds	624	3	806		180	233	5
6	21	Donations	Resident Beds	624	3	50		180	14	6
7	21	Office Expense	Resident Beds	624	3	8,235		180	2,375	7
8	20	Dues & Subscriptions	Resident Beds	624	3	552		180	159	8
9	21	Entertainment & Meals	Resident Beds	624	3	401		180	116	9
10	21	Franchise Tax	Resident Beds	624	3	100		180	29	10
11	22	Payroll Taxes	Resident Beds	624	3	122,839		180	35,434	11
12	26	Insurance	Resident Beds	624	3	1,613		180	465	12
13	22	Health Insurance	Resident Beds	624	3	60,786		180	17,534	13
14	7	Scavenger	Resident Beds	624	3	520		180	150	14
15	35	Equipment Rental	Resident Beds	624	3	1,911		180	551	15
16	2	Sales Taxes	Resident Beds	624	3	418		180	121	16
17	21	Postage	Resident Beds	624	3	1,430		180	413	17
18	19	Legal & Accounting	Resident Beds	624	3	2,703		180	780	18
19	20	Licenses & Permits	Resident Beds	624	3	150		180	43	19
20	25	Travel	Resident Beds	624	3	255		180	74	20
21	30	Depreciation	Resident Beds	624	3	2,550		180	736	21
22	21	Data Processing	Resident Beds	624	3	1,416		180	408	22
23	21	Telephone	Resident Beds	624	3	9,669		180	2,789	23
24										24
25	TOTALS					$ 238,461	$		$ 68,786	25

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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	6	Plant Supervisor Salary	Direct Cost	1	1	$ 88,287	$	1	$ 88,287	1
2	17	Asst. Administrator Salary	Direct Cost	1	1	132,430		1	132,430	2
3	21	Office Manager Salary	Direct Cost	1	1	38,187		1	38,187	3
4	1	Food Service Supervisor Salary	Direct Cost	1	1	363,748		1	363,748	4
5	17	Administrative Salaries	Direct Cost	1	1	85,094		1	85,094	5
6	17	Administrator Salary	Direct Cost	1	1	75,369		1	75,369	6
7	21	Clerical Salaries	Direct Cost	1	1	88,912		1	88,912	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					$ 872,027	$		$ 872,027	25

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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.)**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	213,000	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.)	$	190,141	2
3. Under or (over) accrual (line 2 minus line 1).	$	(22,859)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	196,000	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.	$	173,141	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	224,774	8
2006	212,596	9
2007	210,326	10
2008	212,436	11
2009	190,141	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-06-106-0001-0000	Nursing Home	$ 190,141.00	$ 190,141.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 190,141.00	$ 190,141.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 01/01/2010 Ending: 12/31/2010

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1989	$ 105,000	1
2					2
3	TOTALS			$ 105,000	3

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	180		1989		$ 1,536,832	$ 48,788	31.5	$ 48,780	$ (8)	$ 1,030,748	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System			1990	9,200	292	31.5	292		6,096	9
10	Interior Improvements			1990	32,039	1,019	31.5	1,018	(1)	20,907	10
11	Elevator			1990	5,300	168	31.5	168		3,437	11
12	Tiling & Lobby Office			1990	10,143	321	31.5	321		6,533	12
13	Building Improvements			1991	3,230	103	31.5	103		2,007	13
14	Building Improvements			1991	4,806	153	31.5	153		2,970	14
15	Tiles			1991	11,906	377	31.5	377		7,195	15
16	Radiator Cover			1992	12,400	394	31.5	394		7,404	16
17	Electrical Work			1992	3,500	111	31.5	111		2,077	17
18	Building Improvements			1993	21,476	550	39	551	1	9,568	18
19	Building Improvements			1995	34,754	891	39	891		13,849	19
20	Flooring & Tile			1996	5,355	138	39	137	(1)	1,992	20
21	Generator			1996	35,589	913	39	912	(1)	13,275	21
22	Air Conditioner			1996	16,511	423	39	423		6,152	22
23	Alarm System			1996	3,744	96	39	96		1,396	23
24	Roof			1996	1,200	31	39	31		451	24
25	Hot Water Heater			1996	2,900	74	39	74		1,076	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	548	1	7,596	34
35	Phone System			1997	13,666	351	39	350	(1)	4,831	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	Electrical Work	1997	$ 49,685	$ 1,274	39	$ 1,274	$	$ 17,359	37
38	Central Air Conditioning	1997	35,499	910	39	910		12,402	38
39	New Office Construction	1997	4,442	114	39	114		1,552	39
40	Boiler Insulation	1997	29,412	754	39	754		10,275	40
41	Fire Alarm & Sprinkler	1997	2,475	63	39	64	1	864	41
42	Doors & Construction	1997	8,190	210	39	210		2,791	42
43	Plumbing - Toilets & Pipes	1997	4,719	121	39	121		1,618	43
44	Roof	1998	3,900	100	39	100		1,288	44
45	HVAC Work	1998	2,700	69	39	69		885	45
46	Doors & Construction	1998	2,729	69	39	70	1	855	46
47	Time Clock	1998	5,245	135	39	135		1,686	47
48	Air Conditioner	1998	777	20	39	20		250	48
49	Phone System	1998	1,283	33	39	33		418	49
50	Door	1999	2,500	64	39	64		718	50
51	Fire Damper	1999	1,783	45	39	46	1	520	51
52	Water System	1999	6,000	154	39	154		1,712	52
53	Door Construction	1999	2,500	64	39	64		718	53
54	Kitchen and Tiling	1999	10,250	262	39	263	1	3,100	54
55	New Windows	2001	1,300	33	39	33		298	55
56	Doors & Frame	2001	2,025	53	39	53		476	56
57	Electric Wiring	2001	443	11	39	11		100	57
58	Wall Repair	2001	1,000	26	39	26		234	58
59	Roof Repair	2003	1,150	15	39	15		684	59
60	Brick Paver	2004	40,000	1,026	39	1,025	(1)	6,324	60
61	Tuckpointing	2004	23,518	603	39	603		3,869	61
62	Building Improvement from Building Partnership	1995	74,705	2,118	39	2,121	3	37,474	62
63	Bathroom Remodeling	2005	5,125	132	39	131	(1)	689	63
64	Pump	2005	2,600	66	39	67	1	373	64
65	Water Heater	2005	7,400	190	39	190		965	65
66	Elevator Machine Room	2006	41,767	1,071	39	1,071		4,284	66
67	Boiler Insulation	2006	32,500	833	39	833		3,472	67
68	Symmetry Construction	2006	5,500	141	39	141		599	68
69	Kitchen Fire Safety System	2006	1,600	41	39	42	1	169	69
70	TOTAL (lines 4 thru 69)		$ 2,227,645	$ 66,560		$ 66,557	$ (3)	$ 1,295,603	70

**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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	$ 66,560		$ 66,557	$ (3)	$ 1,295,603	1
2	Elevator Recall System	2006	4,500	116	39	115	(1)	461	2
3	Wireless Temperature Control	2006	3,500	89	39	90	1	367	3
4	Pushbutton Lock	2006	380	10	39	10		40	4
5	Roof	2006	7,100	182	39	182		728	5
6	Boiler	2007	26,890	690	39	689	(1)	2,585	6
7	Elevator Equipment	2007	8,171	209	39	210	1	734	7
8	Power Flame Gas Burner	2007	7,000	180	39	179	(1)	560	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)		$ 2,285,186	$ 68,036		$ 68,032	$ (4)	$ 1,301,078	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: 01/01/2010 Ending: 12/31/2010

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	$ 38,871	$ 2,640	$ 7,774	$ 5,134	5	$ 14,563	71
72	Current Year Purchases	3,148	3,148	630	(2,518)	5	630	72
73	Fully Depreciated Assets	515,448				5	510,078	73
74	Management Company		736	1,698	962			74
75	TOTALS	$ 557,467	$ 6,524	$ 10,102	$ 3,578		$ 525,271	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	$ 258	$ 431	$ 173	5	$ 1,423	76
77										77
78										78
79										79
80	TOTALS			$ 2,245	$ 258	$ 431	$ 173		$ 1,423	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)	$ 2,949,898	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 74,818	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 78,565	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,747	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,827,772	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.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 [X] 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 [X] NO Terms: Annual Lease *

10. Effective dates of current rental agreement:
Beginning 01/01/2010
Ending 12/31/2010

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 3,275 Description: Ice Maker $900 , Copier $1824, Copier Mng Company $551
(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 Attached Schedule			21,363	18
19					19
20					20
21	TOTAL		$	$ 21,363	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respitory	39-2					127		127	13
14	TOTAL			$		$	$ 127		$ 127	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.

STATE OF ILLINOIS

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 692,933	$ 693,258	1
2	Cash-Patient Deposits	8,417	8,417	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	53,465	53,465	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,765	58,765	6
7	Other Prepaid Expenses	24,736	25,404	7
8	Accounts Receivable (owners or related parties)	41,151	38,011	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 879,467	$ 877,320	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	559,708	559,708	16
17	Accumulated Depreciation (book methods)	(755,221)	(1,823,448)	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 **Deposits**	500	500	22
23	Other(specify): **Investment in Partnership**		481,449	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 451,642	$ 1,581,401	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,331,109	$ 2,458,721	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 32,515	$ 32,515	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,125	10,125	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,848	26,848	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,332	20,066	31
32	Accrued Real Estate Taxes(Sch.IX-B)		196,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 86,820	$ 285,554	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	See Attached Schedule	4,199,833	4,199,833	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,199,833	$ 4,199,833	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,286,653	$ 4,485,387	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,955,544)	$ (2,026,666)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,331,109	$ 2,458,721	48

***(See instructions.)**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,601,542)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,601,542)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	559,011	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	(1,913,013)	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)**	$ (1,354,002)	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)**	$ (2,955,544)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,553,601	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,553,601	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***	18,808	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,808	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	3,500	28
28a	Miscellaneous Income	8,964	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,464	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,584,873	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	921,444	31
32	Health Care	1,693,502	32
33	General Administration	1,676,872	33
	B. Capital Expense		
34	Ownership	617,404	34
	C. Ancillary Expense		
35	Special Cost Centers	127	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,007,899	40
41	**Income before Income Taxes (line 30 minus line 40)****	576,974	41
42	**Income Taxes**	(17,963)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 559,011	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: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,899	2,115	$ 75,540	$ 35.72	1
2	Assistant Director of Nursing	1,880	2,016	56,855	28.20	2
3	Registered Nurses	10,697	11,223	219,424	19.55	3
4	Licensed Practical Nurses	2,041	2,236	41,876	18.73	4
5	CNAs & Orderlies	49,928	54,593	616,303	11.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,957	2,197	31,983	14.56	8
9	Activity Director	1,941	2,157	24,289	11.26	9
10	Activity Assistants	3,822	4,251	37,162	8.74	10
11	Social Service Workers	9,951	10,500	133,034	12.67	11
12	Dietician					12
13	Food Service Supervisor	1,981	2,197	39,837	18.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,533	19,185	188,250	9.81	15
16	Dishwashers					16
17	Maintenance Workers	4,250	4,551	65,527	14.40	17
18	Housekeepers	19,387	21,263	202,869	9.54	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	1,033	1,137	16,479	14.49	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,322	6,602	56,416	8.55	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	1,786	1,914	17,770	9.28	31
32	Other Health Care(specify)					32
33	Other(specify) MDS Coordinatr	2,420	2,475	62,727	25.34	33
34	TOTAL (lines 1 - 33)	138,828	150,612	$ 1,886,341 *	$ 12.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,816	1-3	35
36	Medical Director	O	3,000	9-3	36
37	Medical Records Consultant	N	2,168	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	1,900	10-3	39
40	Physical Therapy Consultant	L			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	9,180	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 26,064		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	13,616	$ 327,636	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	13,616	$ 327,636		53

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Annette Betancur	Asst. Administrator	0	$ 16,479
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 16,479

B. Administrative - Other

Description	Amount
Management Fees	$ 940,814
TOTAL (agree to Schedule V, line 17, col. 3)	$ 940,814
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kessler, Orlean, Silver	Accounting	$ 15,950
E Health Data Solutions	Medicare/Medicaid Consltnt	6,042
Automatic Data Processing	Payroll Service	2,710
Accu-Med Services Inc.	Computer	2,685
Health Data Systems Inc.	Computer	3,418
Medifax-EDI, LLC	Computer	866
IL Assoc of Health Care Facilities	Union Negotiations	2,160
Personnel Planners	U/C Consultant	1,604
Innovative LTC Solutions	Billing Service	4,313
See Attached Schedule	Legal	28,293
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 68,041

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,944
Unemployment Compensation Insurance	32,001
FICA Taxes	142,640
Employee Health Insurance	156,535
Employee Meals	19,991
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,540
Union Pension	20,169
Allocation from Management Company	52,969
TOTAL (agree to Schedule V, line 22, col.8)	$ 481,789

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,903
Health Care Worker Background Check	
(Indicate # of checks performed 3)	30
Patient Background Checks 104	1,040
Accurate Biometrics	360
Yellow Pages Advertising	6,450
See Attached	10,573
Allocation from Management Company	202
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(450)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,108

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,410
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,410

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $11,540**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **5-7 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. $ **98,550**
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. $ **19,991** 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? **YES**
Attach invoices and a summary of services for all architect and appraisal fees