FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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:

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 01/01/2015 to 12/31/15 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, Director
(Firm Name & Address) Kessler, Orlean, Silver & Company, P.C., 1101 Lake Cook Road, Suite 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: 01/01/2015 Ending: 12/31/15

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	55,555	796	189	56,540	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,555	796	189	56,540	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.06%

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 [X]

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 0 and days of care provided N/A

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2015 Ending: 12/31/15

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	267,907	19,242	8,870	296,019		296,019	18,950	314,969			1
2	Food Purchase		263,414		263,414	(31,271)	232,143	(322)	231,821			2
3	Housekeeping	217,927	26,994		244,921		244,921		244,921			3
4	Laundry		11,659		11,659		11,659		11,659			4
5	Heat and Other Utilities			94,051	94,051		94,051	3,134	97,185			5
6	Maintenance	67,448	19,235	33	86,716		86,716	273,786	360,502			6
7	Other (specify):*			34,585	34,585		34,585	138	34,723			7
8	TOTAL General Services	553,282	340,544	137,539	1,031,365	(31,271)	1,000,094	295,686	1,295,780			8
	B. Health Care and Programs											
9	Medical Director			2,750	2,750		2,750		2,750			9
10	Nursing and Medical Records	1,128,740	49,653	394,556	1,572,949		1,572,949		1,572,949			10
10a	Therapy	10,959		5,480	16,439		16,439		16,439			10a
11	Activities	73,165	1,805		74,970		74,970		74,970			11
12	Social Services	118,834		5,168	124,002		124,002		124,002			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,331,698	51,458	407,954	1,791,110		1,791,110		1,791,110			16
	C. General Administration											
17	Administrative			1,169,466	1,169,466		1,169,466	(598,547)	570,919			17
18	Directors Fees											18
19	Professional Services			91,873	91,873		91,873	(7,385)	84,488			19
20	Dues, Fees, Subscriptions & Promotions			11,672	11,672		11,672	1,341	13,013			20
21	Clerical & General Office Expenses	68,836		185,655	254,491		254,491	(59,947)	194,544			21
22	Employee Benefits & Payroll Taxes			389,970	389,970	31,271	421,241	52,349	473,590			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,487	3,487		3,487	70	3,557			24
25	Other Admin. Staff Transportation			7,739	7,739		7,739	(917)	6,822			25
26	Insurance-Prop.Liab.Malpractice			71,979	71,979		71,979	1,214	73,193			26
27	Other (specify):*											27
28	TOTAL General Administration	68,836		1,931,841	2,000,677	31,271	2,031,948	(611,822)	1,420,126			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,953,816	392,002	2,477,334	4,823,152		4,823,152	(316,136)	4,507,016			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: 01/01/2015 Ending: 12/31/15

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			26,363	26,363		26,363	265,268	291,631			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,843	6,843		6,843	(6,843)				32
33	Real Estate Taxes							235,703	235,703			33
34	Rent-Facility & Grounds			502,635	502,635		502,635	(502,635)				34
35	Rent-Equipment & Vehicles			26,107	26,107		26,107	137	26,244			35
36	Other (specify):*											36
37	**TOTAL Ownership**			561,948	561,948		561,948	(8,370)	553,578			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			441,773	441,773		441,773		441,773			42
43	Other (specify):* **Loss on Investment**											43
44	**TOTAL Special Cost Centers**			441,773	441,773		441,773		441,773			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,953,816	392,002	3,481,055	5,826,873		5,826,873	(324,506)	5,502,367			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: 01/01/2015 Ending: 12/31/15

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	201,857	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	(322)	2		13
14	Non-Care Related Interest	(6,841)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,109)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,707)	21		18
19	Entertainment				19
20	Contributions	(53,340)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(19,368)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(108,494)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,505)	20		28
29	Other-Attach Schedule Attached Schedule	(13,539)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,368)		$	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)	(320,138)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (320,138)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (324,506)		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

STATE OF ILLINOIS

Winston Manor Cnv & Nursing

ID# 0035782

Report Period Beginning: 01/01/2015

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Trust Fee	$ (175)	21	1
2	Franchise Tax	(100)	21	2
3	Sales Taxes (Management Company)	(119)	2	3
4	Contributions (Management Company)	(984)	21	4
5	Loss on Investments (Management Company)	(12,161)	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**	(13,539)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/15

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	18,950	0	0	0	0	0	0	0	0	18,950	1
2	Food Purchase	(441)	0	119	0	0	0	0	0	0	0	0	(322)	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	3,134	0	0	0	0	0	0	0	0	0	3,134	5
6	Maintenance	0	659	273,127	0	0	0	0	0	0	0	0	273,786	6
7	Other (specify):*	0	26	112	0	0	0	0	0	0	0	0	138	7
8	**TOTAL General Services**	(441)	3,819	292,308	0	0	0	0	0	0	0	0	295,686	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	(598,547)	0	0	0	0	0	0	0	0	(598,547)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(19,368)	0	6,308	5,675	0	0	0	0	0	0	0	(7,385)	19
20	Fees, Subscriptions & Promotions	(1,505)	2,287	559	0	0	0	0	0	0	0	0	1,341	20
21	Clerical & General Office Expenses	(164,800)	5,251	99,542	60	0	0	0	0	0	0	0	(59,947)	21
22	Employee Benefits & Payroll Taxes	0	41,771	10,578	0	0	0	0	0	0	0	0	52,349	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	70	0	0	0	0	0	0	0	0	70	24
25	Other Admin. Staff Transportation	(1,109)	21	171	0	0	0	0	0	0	0	0	(917)	25
26	Insurance-Prop.Liab.Malpractice	0	1,214	0	0	0	0	0	0	0	0	0	1,214	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(186,782)	50,544	(481,319)	5,735	0	0	0	0	0	0	0	(611,822)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(187,223)	54,363	(189,011)	5,735	0	0	0	0	0	0	0	(316,136)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Winston Manor Cnv & Nursing **#** 0035782 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/15

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	201,857	0	58,994	4,417	0	0	0	0	0	0	0	265,268	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,841)	0	0	(2)	0	0	0	0	0	0	0	(6,843)	32
33	Real Estate Taxes	0	0	0	235,703	0	0	0	0	0	0	0	235,703	33
34	Rent-Facility & Grounds	0	12,428	(502,635)	(12,428)	0	0	0	0	0	0	0	(502,635)	34
35	Rent-Equipment & Vehicles	0	0	137	0	0	0	0	0	0	0	0	137	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	195,016	12,428	(443,504)	227,690	0	0	0	0	0	0	0	(8,370)	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):*	(12,161)	0	12,161	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(12,161)	0	12,161	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,368)	66,791	(620,354)	233,425	0	0	0	0	0	0	0	(324,506)	45

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2015 Ending: 12/31/15

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
		Central Home, Inc.	Chicago			

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.	100.00%	$ 21	$ 21	1
2	V	20	Advertising		Nivram Management, Inc.	100.00%	39	39	2
3	V	21	Bank Charges		Nivram Management, Inc.	100.00%	24	24	3
4	V	6	Repairs & Maintenance		Nivram Management, Inc.	100.00%	659	659	4
5	V	5	Utilities		Nivram Management, Inc.	100.00%	3,134	3,134	5
6	V	21	Donations		Nivram Management, Inc.	100.00%	984	984	6
7	V	21	Office Expense		Nivram Management, Inc.	100.00%	4,207	4,207	7
8	V	20	Dues & Subscriptions		Nivram Management, Inc.	100.00%	2,248	2,248	8
9	V	7	Exterminating		Nivram Management, Inc.	100.00%	26	26	9
10	V	21	Taxes - Other		Nivram Management, Inc.	100.00%	36	36	10
11	V	22	Payroll Taxes		Nivram Management, Inc.	100.00%	41,771	41,771	11
12	V	34	Rent		Nivram Management, Inc.	100.00%	12,428	12,428	12
13	V	26	Insurance		Nivram Management, Inc.	100.00%	1,214	1,214	13
14	Total			$			$ 66,791	$ * 66,791	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: 01/01/2015 Ending: 12/31/15

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	20	Marketing	$	Nivram Management, Inc.	100.00%	$ 377	$ 377	15
16	V	22	Health Insurance		Nivram Management, Inc.	100.00%	10,578	10,578	16
17	V	7	Scavenger		Nivram Management, Inc.	100.00%	112	112	17
18	V	35	Equipment Rental		Nivram Management, Inc.	100.00%	137	137	18
19	V	21	Postage		Nivram Management, Inc.	100.00%	708	708	19
20	V	2	Sales Expense		Nivram Management, Inc.	100.00%	119	119	20
21	V	20	License & Permits		Nivram Management, Inc.	100.00%	182	182	21
22	V	25	Travel		Nivram Management, Inc.	100.00%	171	171	22
23	V	30	Depreciation		Nivram Management, Inc.	100.00%	418	418	23
24	V	21	Data Processing		Nivram Management, Inc.	100.00%	1,051	1,051	24
25	V	19	Outside Services		Nivram Management, Inc.	100.00%	6,308	6,308	25
26	V	24	Seminars		Nivram Management, Inc.	100.00%	70	70	26
27	V	21	Telephone		Nivram Management, Inc.	100.00%	1,680	1,680	27
28	V	17	Management Fees	1,169,465	Nivram Management, Inc.	100.00%		(1,169,465)	28
29	V	6	Plant Supervisor Salary		Nivram Management, Inc.	100.00%	273,127	273,127	29
30	V	17	Asst. Supervisor Salary		Nivram Management, Inc.	100.00%	409,691	409,691	30
31	V	21	Office Manager Salary		Nivram Management, Inc.	100.00%	30,643	30,643	31
32	V	1	Food Service Supervisor Salary		Nivram Management, Inc.	100.00%	18,950	18,950	32
33	V	17	Administrative Salary		Nivram Management, Inc.	100.00%	78,035	78,035	33
34	V	17	Administrator Salary		Nivram Management, Inc.	100.00%	83,192	83,192	34
35	V	21	Clerical Salaries		Nivram Management, Inc.	100.00%	65,460	65,460	35
36	V	34	Rental Income	502,635	Pierce Building Partnership	100.00%		(502,635)	36
37	V	43	Loss from Investments		Pierce Building Partnership	100.00%	12,161	12,161	37
38	V	30	Depreciation		Pierce Building Partnership	100.00%	58,576	58,576	38
39	Total			$ 1,672,100			$ 1,051,746	$ * (620,354)	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: 01/01/2015 Ending: 12/31/15

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	19	Legal Fees	$	Pierce Building Partnership	100.00%	$ 4,186	$ 4,186	15
16	V	33	Property Taxes		Pierce Building Partnership	100.00%	227,635	227,635	16
17	V	34	Rental Income	12,428	Hamlin & Arthur Partnership	100.00%		(12,428)	17
18	V	32	Interest Income	2	Hamlin & Arthur Partnership	100.00%		(2)	18
19	V	21	Bank Fees		Hamlin & Arthur Partnership	100.00%	60	60	19
20	V	30	Depreciation Expense		Hamlin & Arthur Partnership	100.00%	4,417	4,417	20
21	V	19	Legal Fees		Hamlin & Arthur Partnership	100.00%	1,489	1,489	21
22	V	33	Real Estate Taxes		Hamlin & Arthur Partnership	100.00%	8,068	8,068	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			$ 12,430			$ 245,855	$ * 233,425	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: 01/01/2015 Ending: 12/31/15

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	187,500	13	33.33	Salary	$ 62,500	17-7	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	56,849	6	31.58	Salary	18,950	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	75.70	1,045,469	5	28.85	Salary	273,127	6-7	3
4	Doreen Mermelstein	Office Manager	Support	0.00	91,927	13	33.33	Salary	30,643	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See above	1,568,204	8	28.85	Salary	409,691	17-7	6
7	Joseph Mermelstein	Administrative	Administrative	24.30	59,465	3	28.85	Salary	15,535	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 810,446		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: 01/01/2015 Ending: 12/31/15

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
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	869	4	$ 103	$	180	$ 21	1
2	20	Advertising	Resident Beds	869	4	186		180	39	2
3	21	Bank Charges	Resident Beds	869	4	115		180	24	3
4	6	Repairs & Maintenance	Resident Beds	869	4	3,185		180	660	4
5	5	Utilities	Resident Beds	869	4	15,130		180	3,134	5
6	21	Donations	Resident Beds	869	4	4,750		180	984	6
7	21	Office Expense	Resident Beds	869	4	20,312		180	4,207	7
8	20	Dues & Subscriptions	Resident Beds	869	4	10,853		180	2,248	8
9	7	Exterminating	Resident Beds	869	4	125		180	26	9
10	21	Taxes- Other	Resident Beds	869	4	172		180	36	10
11	22	Payroll Taxes	Resident Beds	869	4	201,663		180	41,771	11
12	34	Rent	Resident Beds	869	4	60,000		180	12,428	12
13	26	Insurance	Resident Beds	869	4	5,861		180	1,214	13
14	20	Marketing	Resident Beds	869	4	1,819		180	377	14
15	22	Health Insurance	Resident Beds	869	4	51,068		180	10,578	15
16	7	Scavenger	Resident Beds	869	4	540		180	112	16
17	35	Equipment Rental	Resident Beds	869	4	660		180	137	17
18	21	Postage	Resident Beds	869	4	3,418		180	708	18
19	2	Sales Expense	Resident Beds	869	4	576		180	119	19
20	20	License & Permits	Resident Beds	869	4	877		180	182	20
21	25	Travel	Resident Beds	869	4	827		180	171	21
22	30	Depreciatoin	Resident Beds	869	4	2,019		180	418	22
23	21	Data Processing	Resident Beds	869	4	5,073		180	1,051	23
24	19	Outside Services	Resident Beds	869	4	30,453		180	6,308	24
25	TOTALS					$ 419,785	$		$ 86,953	25

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2015 Ending: 12/31/15

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	24	Seminars	Resident Beds	869	4	$ 338	$	180	$ 70	1
2	21	Telephone	Resident Beds	869	4	8,112		180	1,680	2
3	6	Plant Supervisor Salary	Direct Cost	1	1	273,127	273,127	1	273,127	3
4	17	Asst. Supervisor Salary	Direct Cost	1	1	409,691	409,691	1	409,691	4
5	21	Office Manager Salary	Direct Cost	1	1	30,643	30,643	1	30,643	5
6	1	Food Service Supervisory Salary	Direct Cost	1	1	18,950	18,950	1	18,950	6
7	17	Administrative Salary	Direct Cost	1	1	78,035	78,035	1	78,035	7
8	17	Administrator Salary	Direct Cost	1	1	83,192	83,192	1	83,192	8
9	21	Clerical Salaries	Direct Cost	1	1	65,460	65,460	1	65,460	9
10	21	Bank Fees	Resident Beds	869	4	288		180	60	10
11	30	Depreciation	Resident Beds	869	4	21,325		180	4,417	11
12	19	Legal Fees	Resident Beds	869	4	7,190		180	1,489	12
13	33	Real Estate Taxes	Resident Beds	869	4	38,951		180	8,068	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					$ 1,035,302	$ 959,098		$ 974,882	25

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2015 Ending: 12/31/15

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2015 Ending: 12/31/15

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**		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	Line of Credit		X	Working Capital		03/01/15	$ 1,000,000	$	03/01/2016	0.0325	$ 6,843	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,000,000	$			$ 6,843	9
	B. Non-Facility Related*											
10	Offset Interest Income										(6,843)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,843)	14
15	TOTALS (line 9+line14)						$ 1,000,000	$			$	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:** 01/01/2015 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	224,000	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.)	$	230,703	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,703	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	229,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	235,703	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010	198,419	8
2011	230,843	9
2012	250,242	10
2013	262,440	11
2014	267,927	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 Sandord 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-06-106-001-0000	Nursing Home	$ 222,635.00	$ 222,635.00
2.	10-35-325-029-0000	Management Company	$ 4,247.00	$ 756.50
3.	10-35-325-015-0000	Management Company	$ 41,045.00	$ 7,311.66
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 267,927.00	$ 230,703.16

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/15

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).

N/A

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: 01/01/2015 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 55,841	31.5	$ 171,216	$ 115,375	$ 1,519,532	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System			1990	9,200	515	27.5	893	378	9,200	9
10	Interior Improvements			1990	32,039	515	27.5	3,430	2,915	32,039	10
11	Elevator			1990	5,300	516	27.5	590	74	5,300	11
12	Tiling & Lobby Office			1990	10,143	516	27.5	1,176	660	10,143	12
13	Building Improvements			1991	3,230	725	27.5	844	119	2,456	13
14	Building Improvements			1991	4,806		27.5	105	105	3,639	14
15	Tiles			1991	11,906		27.5	983	983	11,906	15
16	Radiator Cover			1992	12,400	578	27.5	1,698	1,120	11,982	16
17	Electrical Work			1992	3,500		27.5	479	479	3,368	17
18	Building Improvements			1993	21,476	781	27.5	4,783	4,002	21,476	18
19	Building Improvements			1995	34,754	1,264	27.5	1,264		32,868	19
20	Flooring & Tile			1996	5,355	195	27.5	1,201	1,006	4,808	20
21	Generator			1996	35,589	1,294	27.5	7,989	6,695	31,992	21
22	Alarm System			1996	3,744	137	27.5	840	703	3,364	22
23	Roof			1996	1,200	44	27.5	270	226	1,084	23
24	Smoke Eater			1993	4,600		10			4,600	24
25	Air Conditioner			1993	2,550		10			2,550	25
26	Carpet			1993	3,527		10			3,527	26
27	Boiler			1993	3,600		10			3,600	27
28	Air Conditioner			1994	5,122		10			5,122	28
29	Hot Water Heater			1995	4,160		10			4,160	29
30	Air Conditioner			1995	2,816		10			2,816	30
31	Glass			1995	647		10			647	31
32	Roof			1997	21,350	776	27.5	4,639	3,863	18,515	32
33	Phone System			1997	13,666	497	27.5	2,957	2,460	11,798	33
34	Electrical Work			1997	49,685	1,807	27.5	10,664	8,857	42,509	34
35	Central Air Conditioning			1997	35,499	1,291	27.5	7,619	6,328	30,370	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: 01/01/2015 Ending: 12/31/15

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	
37	New Office Construction	1997	$ 4,442	$ 161	27.5	$ 954	$ 793	$ 3,802	37
38	Fire Alarm & Sprinkler	1997	2,475	90	27.5	531	441	2,116	38
39	Doors & Construction	1997	8,190	298	27.5	1,728	1,430	3,421	39
40	Plumbing - Toilets & Pipes	1997	4,719	172	27.5	1,000	828	3,981	40
41	Roof	1998	3,900	142	27.5	806	664	3,200	41
42	HVAC Work	1998	2,700	98	27.5	555	457	2,202	42
43	Door & Construction	1998	2,729	99	27.5	545	446	2,153	43
44	Phone System	1998	1,283	47	27.5	263	216	1,043	44
45	Door	1999	2,500	91	27.5	471	380	1,852	45
46	Fire Damper	1999	1,783	65	27.5	338	273	1,331	46
47	Water System	1999	6,000	218	27.5	1,127	909	4,428	47
48	Door Construction	1999	2,500	91	27.5	471	380	1,852	48
49	Kitchen and Tiling	1999	10,250	372	27.5	1,999	1,627	7,884	49
50	New Windows	2001	1,300		27.5	220	220	837	50
51	Doors & Frame	2001	2,025	174	27.5	343	169	1,321	51
52	Electric Wiring	2001	443		27.5	75	75	283	52
53	Wall Repair	2001	1,000		27.5	169	169	650	53
54	Roof Repair	2003	1,150	42	27.5	75	33	1,150	54
55	Brick Paver	2004	40,000	1,455	27.5	5,386	3,931	20,174	55
56	Tuckpointing	2004	23,518	855	27.5	3,230	2,375	12,138	56
57	Building Improvements from Building Partnership	1995	74,705		27.5	14,686	14,686	73,203	57
58	Bathroom Remodeling	2005	5,125	186	27.5	640	454	2,364	58
59	Boiler Insulation	2006	32,500	1,182	27.5	3,679	2,497	13,329	59
60	Symmerty Construction	2006	5,500	200	27.5	627	427	2,276	60
61	Kitchen Fire Safety System	2006	1,600	58	27.5	180	122	652	61
62	Wireless Temperature Control	2006	3,500	128	27.5	502	374	1,813	62
63	Pushbutton Lock	2006	380	13	27.5	43	30	199	63
64	Roof	2006	7,100	258	27.5	791	533	2,856	64
65	Boiler	2007	26,890	978	27.5	2,924	1,946	10,503	65
66	Power Flame Gas Burner	2007	7,000	255	27.5	714	459	2,528	66
67	Fire Alarm	2012	4,300	156	27.5	214	58	566	67
68	Doors Project	2012	3,978	145	27.5	198	53	524	68
69	Elevator Improvements	2012	9,000	327	27.5	448	121	1,184	69
70	TOTAL (lines 4 thru 69)		$ 2,183,181	$ 75,648		$ 269,572	$ 193,924	$ 2,023,186	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: 01/01/2015 Ending: 12/31/15

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		$ 2,183,181	$ 75,648		$ 269,572	$ 193,924	$ 2,023,186	1
2	Water Heater	2013	5,100	186	27.5	186		371	2
3	Relocate Panelboard and Circuites	2014	9,500	346	27.5	346		691	3
4	A/C System	2014	7,650	278	27.5	278		556	4
5	Pipes & Wires	2014	4,800	175	27.5	175		350	5
6	Wiring Upgrade	2014	7,880	286	27.5	286		525	6
7	Sprinkling Sysyem	2015	3,994	145	27.5	145		145	7
8	Elevator	2015	104,660	1,903	27.5	1,903		1,903	8
9	Water Heater	2015	8,369	279	27.5	279		279	9
10	Fire Service equipment, labor, and testing	2015	22,000	67	27.5	67		67	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)		$ 2,357,134	$ 79,313		$ 273,237	$ 193,924	$ 2,028,073	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: 01/01/2015 Ending: 12/31/15

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	$ 54,555	$ 2,192	$ 10,125	$ 7,933	5-7	$ 54,555	71
72	Current Year Purchases	32,490	699	699		5	766	72
73	Fully Depreciated Assets	515,448					515,448	73
74	Mng Company & Bld Partn		7,570	7,570				74
75	TOTALS	$ 602,493	$ 10,461	$ 18,394	$ 7,933		$ 570,769	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	Facility	Ford Taurus	2006	$ 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)	$ 3,066,872	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 89,774	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 291,631	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 201,857	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,601,087	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: 01/01/2015 Ending: 12/31/15

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 01/01/2015
    Ending 12/31/2015

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 2,886 Description: Copier- $1,849; Ice Maker - $900; Mng Company - $137
    (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			23,358	18
19					19
20					20
21	TOTAL		$	$ 23,358	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: 01/01/2015 Ending: 12/31/15

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: 01/01/2015 Ending: 12/31/15

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):									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.

STATE OF ILLINOIS

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 265,722	$ 315,090	1
2	Cash-Patient Deposits	41,085	41,085	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	824,939	824,939	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,789	32,789	6
7	Other Prepaid Expenses	210	210	7
8	Accounts Receivable (owners or related parties)	694	136,508	8
9	Other(specify): Investments		416,348	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,165,439	$ 1,766,969	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	718,605	793,310	15
16	Equipment, at Historical Cost	582,735	582,735	16
17	Accumulated Depreciation (book methods)	(910,247)	(2,431,547)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 391,093	$ 586,330	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,556,532	$ 2,353,299	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 92,994	$ 92,994	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,083	41,083	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,154	64,154	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		229,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,589	10,589	35
	Other Current Liabilities(specify):			
36	Attached Schedule	4,640,625	4,640,625	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,849,445	$ 5,078,445	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)**	$ 4,849,445	$ 5,078,445	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,292,913)	$ (2,725,146)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,556,532	$ 2,353,299	48

***(See instructions.)**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,371,735)	1
2	Restatements (describe):		2
3	**Prior Period Adjustement**	(63,955)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,435,690)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	212,777	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	(1,070,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (857,223)	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)**	$ (3,292,913)	24 *

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

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2015 Ending: 12/31/15

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,022,439	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,022,439	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	2,341	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,341	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***	9,429	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,429	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	4,375	28
28a	Miscellaneous Income	13,768	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,143	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,052,352	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,031,365	31
32	Health Care	1,791,110	32
33	General Administration	2,000,677	33
	B. Capital Expense		
34	Ownership	561,948	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	441,773	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,826,873	40
41	**Income before Income Taxes (line 30 minus line 40)****	225,479	41
42	**Income Taxes**	(12,702)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 212,777	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: 01/01/2015 Ending: 12/31/15

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	1,383	1,589	$ 59,343	$ 37.35	1
2	Assistant Director of Nursing	1,625	1,793	54,206	30.23	2
3	Registered Nurses	14,633	15,499	388,368	25.06	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	44,692	48,642	585,298	12.03	5
6	CNA Trainees					6
7	Licensed Therapist	428	428	10,959	25.61	7
8	Rehab/Therapy Aides	1,803	1,931	41,525	21.50	8
9	Activity Director	1,762	1,978	24,263	12.27	9
10	Activity Assistants	4,875	5,083	48,902	9.62	10
11	Social Service Workers	8,326	8,826	118,834	13.46	11
12	Dietician					12
13	Food Service Supervisor	2,149	2,365	45,711	19.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,997	24,428	222,196	9.10	15
16	Dishwashers					16
17	Maintenance Workers	4,374	4,563	67,448	14.78	17
18	Housekeepers	18,803	20,928	217,927	10.41	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,965	2,093	20,829	9.95	23
24	Clerical	4,612	5,005	48,007	9.59	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)	134,427	145,151	$ 1,953,816 *	$ 13.46	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	$ 8,870	1-3	35
36	Medical Director	O	2,750	9-3	36
37	Medical Records Consultant	N			37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	6,521	10-3	39
40	Physical Therapy Consultant	L	5,480	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			45
46	Other(specify) Dental	S	1,606	10-3	46
47	Psycho Social		5,168	12-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 30,395		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 386,429	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 386,429		53

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2015 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Management Fees	$ 1,169,466
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,169,466
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Attached Schedule		91,873
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 91,873

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,873
Unemployment Compensation Insurance	17,210
FICA Taxes	149,278
Employee Health Insurance	147,346
Employee Meals	31,271
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	21,263
Allocation from Management Company	52,349
TOTAL (agree to Schedule V, line 22, col.8)	$ 473,590

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,743
Health Care Worker Background Check	
(Indicate # of checks performed 12)	396
Patient Background Checks 42	420
Dues & Subscriptions	1,308
Licenses & Permits	3,300
Allocation from Management Company	2,846
Yellow Pages Advertising	1,505
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(1,505)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,013

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,487
Allocation from Management Company	70
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,557

**See instructions.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2015 Ending: 12/31/15

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	N/A		$		$	$	$	$	$	$	$	$	$
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:** 01/01/2015 **Ending:** 12/31/15

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. $ **441,773**
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. $ **31,271** 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?
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees