		FOR BHF USE				

LL1

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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. **IDPH License ID Number:** 0035782

Facility Name: RREM, Inc. d/b/a Winston Manor Nursing Home

Address: 2155 West Pierce Avenue (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	PROPRIETARY	GOVERNMENTAL
[ ] 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: Robb Strukoff Telephone Number: (847) 715-2522
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 01/01/18 to 12/31/18 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)	Robb Strukoff Director
	(Firm Name & Address)	Wipfli LLP 100 Tri-State International, Suite 300, Lincolnshire IL 60069
	(Telephone)	(847) 941-0100 Fax # (847) 941-0101

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 RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	42,848	62	12	42,922	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,848	62	12	42,922	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.33%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing H # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	284,813	9,639	8,965	303,417		303,417		303,417			1
2	Food Purchase		184,523		184,523	(27,808)	156,715		156,715			2
3	Housekeeping	274,470	24,075		298,545		298,545		298,545			3
4	Laundry		8,374		8,374		8,374		8,374			4
5	Heat and Other Utilities			135,365	135,365		135,365	2,850	138,215			5
6	Maintenance		20,274	29,411	49,685		49,685	8,743	58,428			6
7	Other (specify):*							182	182			7
8	TOTAL General Services	559,283	246,885	173,741	979,909	(27,808)	952,101	11,775	963,876			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,142,513	27,507	105,081	1,275,101		1,275,101		1,275,101			10
10a	Therapy											10a
11	Activities	94,378	7,550		101,928		101,928		101,928			11
12	Social Services			7,786	7,786		7,786		7,786			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,236,891	35,057	115,867	1,387,815		1,387,815		1,387,815			16
	C. General Administration											
17	Administrative			587,751	587,751		587,751	(230,932)	356,819			17
18	Directors Fees											18
19	Professional Services			106,062	106,062		106,062	9,870	115,932			19
20	Dues, Fees, Subscriptions & Promotions			6,409	6,409		6,409	6,837	13,246			20
21	Clerical & General Office Expenses	338,667	23,182	29,610	391,459		391,459	131,807	523,266			21
22	Employee Benefits & Payroll Taxes			314,491	314,491	27,808	342,299	27,186	369,485			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,290	3,290		3,290	687	3,977			24
25	Other Admin. Staff Transportation			930	930		930	205	1,135			25
26	Insurance-Prop.Liab.Malpractice			63,603	63,603		63,603	1,217	64,820			26
27	Other (specify):*											27
28	TOTAL General Administration	338,667	23,182	1,112,146	1,473,995	27,808	1,501,803	(53,123)	1,448,680			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,134,841	305,124	1,401,754	3,841,719		3,841,719	(41,348)	3,800,371			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.

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			29,278	29,278		29,278	769	30,047			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							264,676	264,676			33
34	Rent-Facility & Grounds			521,618	521,618		521,618	(521,618)				34
35	Rent-Equipment & Vehicles			17,643	17,643		17,643	236	17,879			35
36	Other (specify):*											36
37	TOTAL Ownership			568,539	568,539		568,539	(255,937)	312,602			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			359,128	359,128		359,128		359,128			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			359,128	359,128		359,128		359,128			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,134,841	305,124	2,329,421	4,769,386		4,769,386	(297,285)	4,472,101			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 RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(35,423)	30		9
10	Interest and Other Investment Income	(2,772)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(160)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(24,935)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,181)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Attached Schedule	(357)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (65,828)		$	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)	(231,457)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (231,457)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (297,285)		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

RREM, Inc. d/b/a Winston Manor Nursing Home

ID# 0035782

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Trust Fee	$ (195)	21	1
2	Franchise Tax	(100)	21	2
3	Contributions (Management Company)	(62)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(357)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(160)	0	160	0	0	0	0	0	0	0	0	0	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	2,850	0	0	0	0	0	0	0	0	0	2,850	5
6	Maintenance	0	1,788	6,955	0	0	0	0	0	0	0	0	8,743	6
7	Other (specify):*	0	0	182	0	0	0	0	0	0	0	0	182	7
8	TOTAL General Services	(160)	4,638	7,297	0	0	0	0	0	0	0	0	11,775	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	(230,932)	0	0	0	0	0	0	0	0	(230,932)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,688	6,182	0	0	0	0	0	0	0	0	9,870	19
20	Fees, Subscriptions & Promotions	0	6,644	193	0	0	0	0	0	0	0	0	6,837	20
21	Clerical & General Office Expenses	(27,473)	2,292	156,930	58	0	0	0	0	0	0	0	131,807	21
22	Employee Benefits & Payroll Taxes	0	0	27,186	0	0	0	0	0	0	0	0	27,186	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	687	0	0	0	0	0	0	0	0	687	24
25	Other Admin. Staff Transportation	0	205	0	0	0	0	0	0	0	0	0	205	25
26	Insurance-Prop.Liab.Malpractice	0	1,217	0	0	0	0	0	0	0	0	0	1,217	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(27,473)	14,046	(39,754)	58	0	0	0	0	0	0	0	(53,123)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,633)	18,684	(32,457)	58	0	0	0	0	0	0	0	(41,348)	29

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(35,423)	1,109	30,666	4,417	0	0	0	0	0	0	0	769	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,772)	0	2,772	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	258,618	6,058	0	0	0	0	0	0	0	264,676	33
34	Rent-Facility & Grounds	0	0	(521,618)	0	0	0	0	0	0	0	0	(521,618)	34
35	Rent-Equipment & Vehicles	0	236	0	0	0	0	0	0	0	0	0	236	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(38,195)	1,345	(229,562)	10,475	0	0	0	0	0	0	0	(255,937)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(65,828)	20,029	(262,019)	10,533	0	0	0	0	0	0	0	(297,285)	45

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mgmt, Inc.	Lincolnwood	Management
Joseph Mermelstein	24.30	Chicago Ridge Nursing & Rehab 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. [ ] 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	20	Advertising	$	Nivram Management, Inc.	100.00%	$ 5,769	$ 5,769	1
2	V	25	Auto Expense		Nivram Management, Inc.	100.00%	205	205	2
3	V	21	Bank Charges		Nivram Management, Inc.	100.00%	3	3	3
4	V	5	Utilities		Nivram Management, Inc.	100.00%	2,850	2,850	4
5	V	6	Repairs and Maintenance		Nivram Management, Inc.	100.00%	1,788	1,788	5
6	V	19	Professional Fees		Nivram Management, Inc.	100.00%	3,688	3,688	6
7	V	30	Depreciation		Nivram Management, Inc.	100.00%	1,109	1,109	7
8	V	21	Contributions		Nivram Management, Inc.	100.00%	62	62	8
9	V	20	Dues and Subscriptions		Nivram Management, Inc.	100.00%	875	875	9
10	V	35	Equipment Rental		Nivram Management, Inc.	100.00%	236	236	10
11	V	21	Miscellaneous		Nivram Management, Inc.	100.00%	1,832	1,832	11
12	V	21	Furnishing Supplies		Nivram Management, Inc.	100.00%	395	395	12
13	V	26	Insurance		Nivram Management, Inc.	100.00%	1,217	1,217	13
14	Total			$			$ 20,029	$ * 20,029	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Health Insurance	$	Nivram Management, Inc.	100.00%	$ 3,698	$ 3,698	15
16	V	19	Legal Fees		Nivram Management, Inc.	100.00%	6,182	6,182	16
17	V	20	Licenses and Permits		Nivram Management, Inc.	100.00%	193	193	17
18	V	21	Office Expense		Nivram Management, Inc.	100.00%	6,560	6,560	18
19	V	21	Postage		Nivram Management, Inc.	100.00%	673	673	19
20	V	34	Rent Expense		Nivram Management, Inc.	100.00%	12,428	12,428	20
21	V	2	Sales Tax		Nivram Management, Inc.	100.00%	160	160	21
22	V	7	Scavenger		Nivram Management, Inc.	100.00%	182	182	22
23	V	24	Travel & Seminars		Nivram Management, Inc.	100.00%	687	687	23
24	V	22	Payroll Taxes		Nivram Management, Inc.	100.00%	23,488	23,488	24
25	V	21	Telephone		Nivram Management, Inc.	100.00%	1,103	1,103	25
26	V	6	Plant Supervisor Salary		Nivram Management, Inc.	100.00%	6,955	6,955	26
27	V	17	Asst. Supervisor Salary		Nivram Management, Inc.	100.00%	10,433	10,433	27
28	V	21	Office Manager Salary		Nivram Management, Inc.	100.00%	3,640	3,640	28
29	V	1	Food Service Supervisor		Nivram Management, Inc.	100.00%			29
30	V	17	Administrative Salary		Nivram Management, Inc.	100.00%			30
31	V	17	Administrator Salary		Nivram Management, Inc.	100.00%	101,694	101,694	31
32	V	21	Clerical Salaries		Nivram Management, Inc.	100.00%	144,954	144,954	32
33	V	17	Management Fees	343,059	Nivram Management, Inc.	100.00%		(343,059)	33
34	V	34	Rental Income	521,618	Pierce Building Partnership	100.00%		(521,618)	34
35	V	32	Gain from Investments	(2,772)	Pierce Building Partnership	100.00%		2,772	35
36	V	30	Depreciation		Pierce Building Partnership	100.00%	30,666	30,666	36
37	V	33	Property Taxes		Pierce Building Partnership	100.00%	258,618	258,618	37
38	V	34	Rental Income	12,428	Hamlin & Arthur Partnership	100.00%		(12,428)	38
39	Total			$ 874,333			$ 612,314	$ * (262,019)	39

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

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	32	Interest Income	$	Hamlin & Arthur Partnership	100.00%	$	$	15
16	V	21	Bank Fees		Hamlin & Arthur Partnership	100.00%	58	58	16
17	V	30	Depreciation Expense		Hamlin & Arthur Partnership	100.00%	4,417	4,417	17
18	V	33	Property Taxes		Hamlin & Arthur Partnership	100.00%	6,058	6,058	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 10,533	$ * 10,533	39

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

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing H # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Marvin Mermelstein	Plant Supervisor	Support	75.70	26,623	4	20.71	Salary	$ 6,955	6-7	1
2	Doreen Mermelstein	Office Manager	Support	0.00	10,920	10	25.00	Salary	3,640	21-7	2
3	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	39,934	6	20.71	Salary	10,433	17-7	3
4	Louise Mermelstein	Dietary Supervisor	Support	0.00							4
5	Joseph Mermelstein	Administrative	Administrative	24.30							5
6	Daniel Mermelstein	Clerical	Support	0.00	4,852	1.4	20.71	Salary	1,268	21-7	6
7	Gavriel Mermelstein	Clerical	Support	0.00	6,840	2	20.71	Salary	1,787	21-7	7
8	Joel Mermelstein	IT Manager	Support	0.00	14,161	8.3	20.71	Salary	3,700	21-7	8
9	Jeffrey Mermelstein	Clerical	Support	0.00	4,281	1.4	20.71	Salary	1,119	21-7	9
10	Joshua Mermestein	Clerical	Support	0.00	9,990	3.3	20.71	Salary	2,610	21-7	10
11	Marvin Mermelstein	Administrative	Management	See Above							11
12											12
13								TOTAL	$ 31,512		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 RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

	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	20	Advertising	Resident Beds	869	4	$ 27,853	$	180	$ 5,769	1
2	25	Auto Expense	Resident Beds	869	4	990		180	205	2
3	21	Bank Charges	Resident Beds	869	4	16		180	3	3
4	5	Utilities	Resident Beds	869	4	13,759		180	2,850	4
5	6	Repairs and Maintenance	Resident Beds	869	4	8,634		180	1,788	5
6	19	Professional Fees	Resident Beds	869	4	17,807		180	3,688	6
7	30	Depreciation	Resident Beds	869	4	5,353		180	1,109	7
8	21	Contributions	Resident Beds	869	4	300		180	62	8
9	20	Dues and Subscriptions	Resident Beds	869	4	4,222		180	875	9
10	35	Equipment Rental	Resident Beds	869	4	1,137		180	236	10
11	21	Miscellaneous	Resident Beds	869	4	8,842		180	1,831	11
12	21	Furnishing Supplies	Resident Beds	869	4	1,909		180	395	12
13	26	Insurance	Resident Beds	869	4	5,876		180	1,217	13
14	22	Health Insurance	Resident Beds	869	4	17,852		180	3,698	14
15	19	Legal Fees	Resident Beds	869	4	29,846		180	6,182	15
16	20	Licenses and Permits	Resident Beds	869	4	933		180	193	16
17	21	Office Expense	Resident Beds	869	4	31,672		180	6,560	17
18	21	Postage	Resident Beds	869	4	3,248		180	673	18
19	34	Rent Expense	Resident Beds	869	4	60,000		180	12,428	19
20	2	Sales Tax	Resident Beds	869	4	774		180	160	20
21	7	Scavenger	Resident Beds	869	4	878		180	182	21
22	24	Travel & Seminars	Resident Beds	869	4	3,315		180	687	22
23	22	Payroll Taxes	Resident Beds	869	4	113,396		180	23,488	23
24	21	Telephone	Resident Beds	869	4	5,327		180	1,103	24
25	TOTALS					$ 363,939	$		$ 75,382	25

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N Hamlin Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847 679-7484
Fax Number: (847 679-7494

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 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	$ 6,955	$ 6,955	1	$ 6,955	1
2	17	Asst. Supervisor Salary	Direct Cost	1	1	10,433	10,433	1	10,433	2
3	21	Office Manager Salary	Direct Cost	1	1	3,640	3,640	1	3,640	3
4	1	Food Service Supervisor	Direct Cost	1	1			1		4
5	17	Administrative Salary	Direct Cost	1	1			1		5
6	17	Administrator Salary	Direct Cost	1	1	101,694	101,694	1	101,694	6
7	21	Clerical Salary	Direct Cost	1	1	144,954	144,954	1	144,954	7
8	21	Bank Fees	Resident Beds	869	4	325		180	58	8
9	30	Depreciation Expense	Resident Beds	869	4	24,797		180	4,417	9
10	33	Property Taxes	Resident Beds	869	4	34,008		180	6,058	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					$ 326,806	$ 267,676		$ 278,209	25

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing H # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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							$	$			$	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.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RREM, Inc. d/b/a Winston Manor Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035782

CONTACT PERSON REGARDING THIS REPORT Robb Strukoff

TELEPHONE **(847) 941-0100** FAX #: **(847) 941-0101**

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-06-106-001-0000	Nursing Home	$ 241,618.00	$ 241,618.00
2.	10-35-325-029-0000	Management Company	$ 4,760.74	$ 848.00
3.	10-35-325-015-0000	Management Company	$ 29,246.83	$ 5,210.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 275,625.57	$ 247,676.00

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? 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2017 report.	$	232,000	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.)	$	247,676	2
3. Under or (over) accrual (line 2 minus line 1).	$	15,676	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	232,000	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.	$	247,676	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	262,440	8
2014	267,927	9
2015	252,957	10
2016	257,087	11
2017	250,554	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

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

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	20,940	31.5		(20,940)	1,536,832	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System			1990	9,200	493	27.5		(493)	9,200	9
10	Interior Improvements			1990	32,039	493	27.5		(493)	32,039	10
11	Elevator			1990	5,300	493	27.5		(493)	5,300	11
12	Tiling & Lobby Office			1990	10,143	492	27.5		(492)	10,143	12
13	Building Improvements			1991	3,230	242	27.5		(242)	3,230	13
14	Building Improvements			1991	4,806	242	27.5	175	(67)	4,094	14
15	Tiles			1991	11,906	241	27.5		(241)	11,906	15
16	Radiator Cover			1992	12,400	289	27.5		(289)	12,400	16
17	Electrical Work			1992	3,500	289	27.5		(289)	3,500	17
18	Building Improvements			1993	21,476	780	27.5		(780)	21,476	18
19	Building Improvements			1995	34,754	1,264	27.5	622	(642)	34,754	19
20	Flooring & Tile			1996	5,355	194	27.5		(194)	5,355	20
21	Generator			1996	35,589	1,294	27.5		(1,294)	35,589	21
22	Alarm System			1996	3,744	136	27.5		(136)	3,744	22
23	Roof			1996	1,200	44	27.5		(44)	1,200	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		(776)	21,350	32
33	Phone System			1997	13,666	497	27.5		(497)	13,666	33
34	Electrical Work			1997	49,685	1,806	27.5		(1,806)	49,685	34
35	Central Air Conditioning			1997	35,499	1,291	27.5		(1,291)	35,499	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 RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$	$ (161)	$ 4,442	37
38	Fire Alarm & Sprinkler	1997	2,475	90	27.5		(90)	2,475	38
39	Doors & Construction	1997	8,190	298	27.5	298		5,745	39
40	Plumbing - Toilets & Pipes	1997	4,719	171	27.5		(171)	4,719	40
41	Roof	1998	3,900	142	27.5		(142)	3,900	41
42	HVAC Work	1998	2,700	98	27.5		(98)	2,700	42
43	Door & Construction	1998	2,729	99	27.5		(99)	2,729	43
44	Phone System	1998	1,283	46	27.5		(46)	1,283	44
45	Door	1999	2,500	91	27.5	86	(5)	2,500	45
46	Fire Damper	1999	1,783	65	27.5	49	(16)	1,783	46
47	Water System	1999	6,000	219	27.5	219		5,992	47
48	Door Construction	1999	2,500	91	27.5	60	(31)	2,474	48
49	Kitchen and Tiling	1999	10,250	373	27.5		(373)	10,250	49
50	New Windows	2001	1,300	44	27.5	47	3	1,151	50
51	Doors & Frame	2001	2,025	44	27.5	74	30	1,812	51
52	Electric Wiring	2001	443	43	27.5	16	(27)	390	52
53	Wall Repair	2001	1,000	43	27.5	36	(7)	891	53
54	Roof Repair	2003	1,150		27.5			1,150	54
55	Brick Paver	2004	40,000	1,455	27.5	1,455		28,470	55
56	Tuckpointing	2004	23,518	856	27.5	855	(1)	17,078	56
57	Building Improvements from Building Partnership	1995	74,705	2,682	27.5		(2,682)	74,705	57
58	Bathroom Remodeling	2005	5,125	187	27.5	186	(1)	3,376	58
59	Boiler Insulation	2006	32,500	1,182	27.5	1,182		19,372	59
60	Symmerty Construction	2006	5,500	200	27.5	200		3,303	60
61	Kitchen Fire Safety System	2006	1,600	58	27.5	58		948	61
62	Wireless Temperature Control	2006	3,500	127	27.5	127		2,569	62
63	Pushbutton Lock	2006	380	14	27.5	14		270	63
64	Roof	2006	7,100	258	27.5	258		4,163	64
65	Boiler	2007	26,890	978	27.5	978		15,383	65
66	Power Flame Gas Burner	2007	7,000	255	27.5	255		3,752	66
67	Fire Alarm	2012	4,300	156	27.5	156		1,092	67
68	Doors Project	2012	3,978	145	27.5	145		1,012	68
69	Elevator Improvements	2012	9,000	328	27.5	327	(1)	2,286	69
70	TOTAL (lines 4 thru 69)		$ 2,183,181	$ 43,295		$ 7,878	$ (35,417)	$ 2,112,149	70

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

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 43,295		$ 7,878	$ (35,417)	$ 2,112,149	1
2	Water Heater	2013	5,100	186	27.5	185	(1)	927	2
3	Relocate Panelboard and Circuites	2014	9,500	346	27.5	345	(1)	1,727	3
4	A/C System	2014	7,650	278	27.5	278		1,390	4
5	Pipes & Wires	2014	4,800	175	27.5	175		875	5
6	Wiring Upgrade	2014	7,880	286	27.5	287	1	1,385	6
7	Sprinkling Sysyem	2015	3,994	146	27.5	145	(1)	580	7
8	Elevator	2015	104,660	3,806	27.5	3,806		13,321	8
9	Water Heater	2015	8,369	305	27.5	304	(1)	1,191	9
10	Fire Service equipment, labor, and testing	2015	22,000	800	27.5	800		2,467	10
11	Elevator Motor & Break Assembly	2016	19,837	722	27.5	721	(1)	2,103	11
12	Refrigerator Cooler Components	2016	8,500	309	27.5	309		798	12
13	Air Conditioning Unit	2016	20,938	762	27.5	761	(1)	1,966	13
14	Elevator Valve	2016	3,800	138	27.5	138		345	14
15	Circuit Breaker Load	2018	3,800	69	27.5	69		69	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)		$ 2,414,009	$ 51,623		$ 16,201	$ (35,422)	$ 2,141,293	34

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

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 19,833	$ 3,252	$ 2,962	$ (290)	5	$ 14,095	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	563,976				5-7	563,976	73
74	Mgmt Company & Bldg Partn		10,885	10,884	(1)			74
75	TOTALS	$ 583,809	$ 14,137	$ 13,846	$ (291)		$ 578,071	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)	$ 3,105,063	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 65,760	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,047	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (35,713)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,721,609	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 RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

10. Effective dates of current rental agreement:
Beginning 01/01/2018
Ending 12/31/2018

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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 *

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: $ 2,980 Description: Copier - $1,843; Ice Maker - $900; Mgmt Company - $237
(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	See Attached Schedule		$	$ 14,900	17
18					18
19					19
20					20
21	TOTAL		$	$ 14,900	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 RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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.

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 837,680	$ 837,730	1
2	Cash-Patient Deposits	51,583	51,583	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(163,979)	(163,979)	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,178	30,178	6
7	Other Prepaid Expenses	21,000	21,000	7
8	Accounts Receivable (owners or related parties)	500		8
9	Other(specify): Investments		401,846	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 776,962	$ 1,178,358	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	775,480	850,185	15
16	Equipment, at Historical Cost	586,052	586,052	16
17	Accumulated Depreciation (book methods)	(1,005,358)	(2,611,457)	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)**	$ 356,174	$ 466,612	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,133,136	$ 1,644,970	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 87,290	$ 87,290	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	71,556	71,556	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,029	85,029	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		249,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Attached Schedule	4,354,210	4,375,210	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,598,085	$ 4,868,085	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)**	$ 4,598,085	$ 4,868,085	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,461,949)	$ (3,220,115)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,136,136	$ 1,647,970	48

*(See instructions.)

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home **#** 0035782 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,552,493)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,552,493)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	90,544	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 90,544	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)**	$ (3,461,949)	24 *

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

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 4,809,080	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,809,080	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	4,470	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(1,381)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,089	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,085	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,085	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Vending Income	9,553	28
28a	Miscellaneous Income	23,957	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 33,510	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,862,764	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	979,909	31
32	Health Care	1,387,815	32
33	General Administration	1,473,995	33
	B. Capital Expense		
34	Ownership	568,539	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	359,128	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,769,386	40
41	**Income before Income Taxes (line 30 minus line 40)****	93,378	41
42	**Income Taxes**	(2,834)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 90,544	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? ____________ 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 RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,031	1,085	$ 36,373	$ 33.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,728	14,603	531,882	36.42	3
4	Licensed Practical Nurses	2,409	2,478	65,126	26.28	4
5	CNAs & Orderlies	34,706	38,728	545,505	14.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,989	7,426	94,378	12.71	10
11	Social Service Workers	7,778	8,058	122,157	15.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,451	21,183	284,813	13.45	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	18,181	20,307	274,470	13.52	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,708	6,160	73,084	11.86	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	2,215	2,351	29,769	12.66	31
32	Other Health Care(specify)	2,046	2,133	50,326	23.59	32
33	Other(specify)	2,006	2,059	26,958	13.09	33
34	TOTAL (lines 1 - 33)	116,248	126,571	$ 2,134,841 *	$ 16.87	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,965	1-3	35
36	Medical Director		3,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,865	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psycho Social		7,786	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,616		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,611	$ 95,076	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,611	$ 95,076		53

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 343,059
Management Fees - Marvin Mermelstein	244,692
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 587,751

C. Professional Services

Vendor/Payee	Type	Amount
Attached Schedule		$ 106,062
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 106,062

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,607
Unemployment Compensation Insurance	10,468
FICA Taxes	161,757
Employee Health Insurance	91,194
Employee Meals	28,559
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	20,465
Allocation from Management Company	26,435
TOTAL (agree to Schedule V, line 22, col.8)	$ 369,485

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	94
Health Care Worker Background Check (Indicate # of checks performed 16)	588
Patient Background Checks 32	320
Dues & Subscriptions	1,578
Licenses & Permits	4,737
Allocation from Management Company	5,929
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,246

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,290
Allocation from Management Company	687
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,977

**See instructions.

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 politica 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 fo 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. $ **359,128**
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 tc the Department, in addition to the daily rate, been properly classifiec 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 foi 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. $ **27,808** 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 foi 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? **N/A**
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 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees