		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I.

IDPH License ID Number: 0035782

Facility Name: Winston Manor Cnv Nursing

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 01/01/90

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: Mendel Schneider Telephone Number: 847-933-1274
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 01/01/2020 to 12/31/2020 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) See Accountant's Report Attached	(Date)
	(Print Name and Title)	
	(Firm Name & Address) Mendel S Schneider & Associates CPA PC 4051 Old Orchard Rd Skokie Illinois 60076	
	(Telephone) 847-933-1274	Fax # 847-933-1283

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: 01/01/2020 Ending: 12/31/2020

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	180	Intermediate (ICF)	180	65,880	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,880	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	26,403			26,403	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,403			26,403	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.08%

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)
None

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 01/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/90 NO [ ]

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

Medicare Intermediary ______

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number: Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	249,809	6,954	16,180	272,943		272,943		272,943			1
2	Food Purchase		144,251		144,251		144,251		144,251			2
3	Housekeeping	269,379	14,251	11,978	295,608		295,608		295,608			3
4	Laundry		9,179		9,179		9,179		9,179			4
5	Heat and Other Utilities			101,944	101,944		101,944	2,029	103,973			5
6	Maintenance			44,996	44,996		44,996	1,197	46,193			6
7	Other (specify):*											7
8	**TOTAL General Services**	519,188	174,635	175,098	868,921		868,921	3,226	872,147			8
	B. Health Care and Programs											
9	Medical Director			2,750	2,750		2,750		2,750			9
10	Nursing and Medical Records	1,249,734	47,110	149,081	1,445,925		1,445,925		1,445,925			10
10a	Therapy											10a
11	Activities	62,942	250		63,192		63,192		63,192			11
12	Social Services	143,198			143,198		143,198		143,198			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,455,874	47,360	151,831	1,655,065		1,655,065		1,655,065			16
	C. General Administration											
17	Administrative			278,318	278,318		278,318	(150,085)	128,233			17
18	Directors Fees											18
19	Professional Services			49,361	49,361		49,361	11,350	60,711			19
20	Dues, Fees, Subscriptions & Promotions			5,643	5,643		5,643	(325)	5,318			20
21	Clerical & General Office Expenses	203,528	36,839	62,896	303,263		303,263	176,138	479,401			21
22	Employee Benefits & Payroll Taxes			313,752	313,752		313,752	28,712	342,464			22
23	Inservice Training & Education											23
24	Travel and Seminar			450	450		450		450			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			160,453	160,453		160,453	2,213	162,666			26
27	Other (specify):*											27
28	**TOTAL General Administration**	203,528	36,839	870,873	1,111,240		1,111,240	68,003	1,179,243			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,178,590	258,834	1,197,802	3,635,226		3,635,226	71,229	3,706,455			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			47,507	47,507		47,507	(24,914)	22,593			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							264,253	264,253			33
34	Rent-Facility & Grounds			523,071	523,071		523,071	(523,071)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			570,578	570,578		570,578	(283,732)	286,846			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			256,086	256,086		256,086		256,086			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			256,086	256,086		256,086		256,086			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,178,590	258,834	2,024,466	4,461,890		4,461,890	(212,503)	4,249,387			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: 01/01/2020 Ending: 12/31/2020

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	(26,476)	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				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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(325)	20		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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,801)		$	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)	(185,702)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (185,702)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (212,503)		37

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

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

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

Winston Manor Cnv Nursing

ID# 0035782

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	0	0	0	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	0	2,029	0	0	0	0	0	0	0	0	2,029	5
6	Maintenance	0	0	1,197	0	0	0	0	0	0	0	0	1,197	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	3,226	0	0	0	0	0	0	0	0	3,226	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	(150,085)	0	0	0	0	0	0	0	0	(150,085)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	11,350	0	0	0	0	0	0	0	0	11,350	19
20	Fees, Subscriptions & Promotions	(325)	0	0	0	0	0	0	0	0	0	0	(325)	20
21	Clerical & General Office Expenses	0	0	176,138	0	0	0	0	0	0	0	0	176,138	21
22	Employee Benefits & Payroll Taxes	0	0	28,712	0	0	0	0	0	0	0	0	28,712	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,213	0	0	0	0	0	0	0	0	2,213	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(325)	0	68,328	0	0	0	0	0	0	0	0	68,003	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(325)	0	71,554	0	0	0	0	0	0	0	0	71,229	29

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(26,476)	1,562	0	0	0	0	0	0	0	0	0	(24,914)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	255,052	9,201	0	0	0	0	0	0	0	0	264,253	33
34	Rent-Facility & Grounds	0	(523,071)	0	0	0	0	0	0	0	0	0	(523,071)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(26,476)	(266,457)	9,201	0	0	0	0	0	0	0	0	(283,732)	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)**	(26,801)	(266,457)	80,755	0	0	0	0	0	0	0	0	(212,503)	45

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	75.7	Balmoral Home Inc	Chicago	Pierce Bldg Part	Lincolnwood	Bldg Rental
Joseph Mermelstein	24.3	Central Home Inc	Chicago	Nivram Mgmt Co	Lincolnwood	Mgmt Co
		Paul House Health Care Center	Chicago			
		Chicago Ridge Nursing & Rehab Ctr	Chicago Ridge			

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	34	Rent	$ 523,071	Pierce Building Partnership	100.00%	$	$ (523,071)	1
2	V	30	Depreciation		Pierce Building Partnership		1,562	1,562	2
3	V	33	Real Estate Tax		Pierce Building Partnership		255,052	255,052	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 523,071			$ 256,614	$ * (266,457)	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: 01/01/2020 Ending: 12/31/2020

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	17	Management Fees	$ 278,318	Nivram Management Inc	100.00%	$	$ (278,318)	15
16	V	21	Payroll		Nivram Management Inc		106,930	106,930	16
17	V	22	Payroll Taxes		Nivram Management Inc		28,712	28,712	17
18	V	33	Real Estate Tax		Nivram Management Inc		9,201	9,201	18
19	V	5	Utilities		Nivram Management Inc		2,029	2,029	19
20	V	6	Repairs & Maintenance		Nivram Management Inc		1,197	1,197	20
21	V	26	Insurance		Nivram Management Inc		2,213	2,213	21
22	V	19	Professional Fees		Nivram Management Inc		11,350	11,350	22
23	V	21	Office		Nivram Management Inc		23,462	23,462	23
24	V	17	Marvin Mermelstein		Nivram Management Inc		15,434	15,434	24
25	V	21	Doreen Mermelstein		Nivram Management Inc		1,585	1,585	25
26	V	21	Jacob Mermelstein		Nivram Management Inc		23,902	23,902	26
27	V	21	Joel Mermelstein		Nivram Management Inc		20,259	20,259	27
28	V	17	Administrator Salary		Nivram Management Inc		112,799	112,799	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			$ 278,318			$ 359,073	$ * 80,755	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: 01/01/2020 Ending: 12/31/2020

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 Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Marvin Mermelstein		Adm	75.70	68,512	10	20.00	Salary	$ 15,434	17	1
2	Doreen Mermelstein		Clerical		7,038	10	20.00	Salary	1,585	21	2
3	Jacob Mermelstein		Clerical		106,098	10	20.00	Salary	23,902	21	3
4	Joel Mermelstein		Clerical		89,928	10	20.00	Salary	20,259	21	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 61,180		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: 01/01/2020 Ending: 2/31/2020

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 Mgmt Co
Street Address: 6500 N hamlin
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	21	Payroll	Resident Beds	979	5	$ 581,580	$ 581,580	180	$ 106,930	1
2	22	Payroll Taxes	Resident Beds	979	5	156,164		180	28,712	2
3	33	Real Estate Tax	Resident Beds	979	5	50,044		180	9,201	3
4	5	Utilities	Resident Beds	979	5	11,038		180	2,029	4
5	6	Repairs & Maintenance	Resident Beds	979	5	6,509		180	1,197	5
6	26	Insurance	Resident Beds	979	5	12,037		180	2,213	6
7	19	Professional Fees	Resident Beds	979	5	61,734		180	11,350	7
8	21	Office	Resident Beds	979	5	127,608		180	23,462	8
9	17	Marvin Mermelstein	Resident Beds	979	5	83,946	83,946	180	15,434	9
10	21	Doreen Mermelstein	Resident Beds	979	5	8,623	8,623	180	1,585	10
11	21	Jacob Mermelstein	Resident Beds	979	5	130,000	130,000	180	23,902	11
12	21	Joel Mermelstein	Resident Beds	979	5	110,187	110,187	180	20,259	12
13	17	Administrator Salary	Resident Beds			112,799	112,799		112,799	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					$ 1,452,269	$ 1,027,135		$ 359,073	25

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.)**

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 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.)	$	250,316	2
3. Under or (over) accrual (line 2 minus line 1).	$	18,316	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	245,937	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.	$	264,253	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	252,957	8
	2016	257,087	9
	2017	250,554	10
	2018	237,060	11
	2019	241,115	12

Line 4: 241115 x 1.02

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	$		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.**

2019 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 Robb Strukoff

TELEPHONE 847-715-2522 FAX #: 847-941-0101

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-06-106-001-0000	Facility	$ 241,114.79	$ 241,114.79
2.			$	$
3.			$	$
4.	Allocated from Mgmt Co		$ 50,044.00	$ 9,201.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 291,158.79	$ 250,315.79

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ________ YES ________ 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

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? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	Facility		1989	$ 105,000	1
2					2
3	TOTALS			$ 105,000	3

XI. OWNERSHIP COSTS (continued)

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

	1 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	$	31.5	$	$	$ 1,536,832	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System			1990	9,200		27.5			9,200	9
10	Interior Improvements			1990	32,039		27.5			32,039	10
11	Elevator			1990	5,300		27.5			5,300	11
12	Tiling & Lobby Office			1990	10,143		27.5			10,143	12
13	Building Improvements			1991	3,230		27.5			3,230	13
14	Building Improvements			1991	4,806		27.5	175	175	4,444	14
15	Tiles			1991	11,906		27.5			11,906	15
16	Radiator Cover			1992	12,400		27.5			12,400	16
17	Electrical Work			1992	3,500		27.5			3,500	17
18	Building Improvements			1993	21,476	784	27.5		(784)	21,476	18
19	Building Improvements			1995	34,754	1,264	27.5		(1,264)	34,754	19
20	Flooring & Tile			1996	5,355	195	27.5		(195)	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	43	27.5		(43)	1,200	23
24	Smoke Eater			1993	4,600		10			4,600	24
25	A/C			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	A/C			1994	5,122		10			5,122	28
29	Hot Water Heater			1995	4,160		10			4,160	29
30	A/C			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	1,807	27.5		(1,807)	49,685	34
35	Central A/C			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 Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		6,341	39
40	Plumbing-Toilets & Pipes	1997	4,719	172	27.5		(172)	4,719	40
41	Roof	1998	3,900	142	27.5		(142)	3,900	41
42	HVAC	1998	2,700	98	27.5		(98)	2,700	42
43	Door & Construction	1998	2,729	98	27.5		(98)	2,729	43
44	Phone System	1998	1,283	47	27.5		(47)	1,283	44
45	Door	1999	2,500	91	27.5		(91)	2,500	45
46	Fire Damper	1999	1,783	65	27.5		(65)	1,783	46
47	Water System	1999	6,000	218	27.5		(218)	6,000	47
48	Door Construction	1999	2,500	91	27.5		(91)	2,500	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	1,279	50
51	Doors & Frames	2001	2,025	44	27.5	74	30	1,960	51
52	Electric Wiring	2001	443	43	27.5	16	(27)	422	52
53	Wall Repair	2001	1,000	43	27.5	36	(7)	963	53
54	Roof Repair	2003	1,150		27.5			1,150	54
55	Brick Paver	2004	40,000	1,450	27.5	1,450		31,370	55
56	Tuckpointing	2004	23,518	852	27.5	852		18,782	56
57	Bldg Imp	1995	74,705		27.5			74,705	57
58	Bathroom Remodeling	2005	5,125	187	27.5	187		3,750	58
59	Boiler Insulation	2006	32,500	1,179	27.5	1,179		21,730	59
60	Symmetry Construction	2006	5,500	201	27.5	201		3,705	60
61	Kitchen Fire Safety System	2006	1,600	58	27.5	58		1,064	61
62	Wireless Temp Control	2006	3,500	127	27.5	127		2,823	62
63	Lock	2006	380	14	27.5	14		298	63
64	Roof	2006	7,100	259	27.5	259		4,681	64
65	Boiler Insulation	2007	26,890	980	27.5	980		17,343	65
66	Power Flame Gas Burner	2007	7,000	255	27.5	255		4,262	66
67	Fire Alarm	2012	4,300	157	27.5	157		1,406	67
68	Doors Project	2012	3,978	144	27.5	144		1,300	68
69	Elevator Improvements	2012	9,000	327	27.5	327		2,940	69
70	TOTAL (lines 4 thru 69)		$ 2,183,181	$ 16,395		$ 6,836	$ (9,559)	$ 2,125,889	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: 01/01/2020 Ending: 12/31/2020

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	$ 16,395		$ 6,836	$ (9,559)	$ 2,125,889	1
2	Water Heater	2013	5,100	186	27.5	186		1,299	2
3	Relocate Panelboard & Circuits	2014	9,500	345	27.5	345		2,417	3
4	A/C	2014	7,650	279	27.5	279		1,948	4
5	Pipes & Wires	2014	4,800	174	27.5	174		1,223	5
6	Wiring Upgrade	2014	7,880	286	27.5	286		1,957	6
7	Sprinkler System	2015	3,994	145	27.5	145		873	7
8	Elevator	2015	104,660	4,160	27.5	4,160		21,641	8
9	Water Heater	2015	8,369	305	27.5	305		1,801	9
10	Fire Service	2015	22,000	799	27.5	799		4,065	10
11	Elevator Motor & Break assembly	2016	19,837	723	27.5	723		3,549	11
12	Refrigerator Cooler Components	2016	8,500	309	27.5	309		1,416	12
13	A/C Unit	2016	20,938	760	27.5	760		3,486	13
14	Elevator Valve	2016	3,800	138	27.5	138		621	14
15	Circuit Breaker Load	2018	3,800	138	27.5	138		345	15
16	Backflow	2019	4,955	471	15	471		719	16
17	Roof	2019	9,000	855	15	855		1,305	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)		$ 2,427,964	$ 26,468		$ 16,909	$ (9,559)	$ 2,174,554	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: 01/01/2020 Ending: 12/31/2020

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	$ 2,650	$ 2,834	$ 184	7	$ 19,891	71
72	Current Year Purchases	19,951	19,951	2,850	(17,101)	7	2,850	72
73	Fully Depreciated Assets	566,221					566,221	73
74								74
75	TOTALS	$ 606,005	$ 22,601	$ 5,684	$ (16,917)		$ 588,962	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 3,138,969	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 49,069	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,593	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (26,476)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,763,516	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (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					18
19					19
20					20
21	TOTAL		$	$	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: 01/01/2020 Ending: 12/31/2020

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.)

		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.

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 1,434,692	$ 1,434,692	1
2	Cash-Patient Deposits	151,998	151,998	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	512,212	512,212	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,320	21,320	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	8,341	8,341	8
9	Other(specify): Investments		401,846	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,128,563	$ 2,530,409	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	847,392	922,097	15
16	Equipment, at Historical Cost	586,052	586,052	16
17	Accumulated Depreciation (book methods)	(1,081,314)	(2,691,575)	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)**	$ 352,130	$ 458,406	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,480,693	$ 2,988,815	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 221,757	$ 221,757	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	146,846	146,846	28
29	Short-Term Notes Payable	466,717	466,717	29
30	Accrued Salaries Payable	80,967	80,967	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,228	2,228	31
32	Accrued Real Estate Taxes(Sch.IX-B)		245,937	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Acc Mgmt Fee & Rent	4,804,320	4,804,320	36
37	Credit Balances	723,873	723,873	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,446,708	$ 6,692,645	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)**	$ 6,446,708	$ 6,692,645	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,966,015)	$ (3,703,830)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,480,693	$ 2,988,815	48

*(See instructions.)

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,871,859)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,871,859)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(94,156)	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)**	$ (94,156)	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)**	$ (3,966,015)	24 *

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

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 3,331,319	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,331,319	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,999	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,999	26
	E. Other Revenue (specify):** **		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Stimulus Income	1,027,416	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,027,416	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,367,734	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	868,921	31
32	Health Care	1,655,065	32
33	General Administration	1,111,240	33
	B. Capital Expense		
34	Ownership	570,578	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	256,086	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,461,890	40
41	**Income before Income Taxes (line 30 minus line 40)****	(94,156)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (94,156)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,331,319	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)	$ 3,331,319	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No,CashBas **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.**

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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
2	Assistant Director of Nursing					2
3	Registered Nurses	15,260	16,373	579,204	35.38	3
4	Licensed Practical Nurses	3,568	3,766	109,610	29.11	4
5	CNAs & Orderlies	29,055	32,961	560,920	17.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,616	4,030	62,942	15.62	10
11	Social Service Workers	7,135	7,728	143,198	18.53	11
12	Dietician	304	304	4,621	15.20	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,382	15,433	245,188	15.89	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	15,203	16,433	269,379	16.39	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,374	5,846	85,479	14.62	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	2,172	2,364	33,614	14.22	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	2,937	3,105	84,435	27.19	33
34	TOTAL (lines 1 - 33)	98,006	108,343	$ 2,178,590 *	$ 20.11	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	Monthly	$ 7,656	1-3	35
36	Medical Director	Monthly	2,750	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 10,406		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,170	$ 70,460	10-3	50
51	Licensed Practical Nurses	1,180	59,424	10-3	51
52	Certified Nurse Assistants/Aides	550	16,747	10-3	52
53	TOTAL (lines 50 - 52)	2,900	$ 146,631		53

Facility Name & ID Number: Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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
Nivram Mgmt Inc-Mgmt Fees	$ 278,318
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 278,318

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider CPA	Accounting	$ 14,000
Compliagent	Bus Mgmt Cons	13,586
Jackson Lewis	Legal	2,134
Perfect Staffing	Placement Fee	3,780
Govig & assoc	Placement Fee	6,000
Personnel Planners	UC Tax Cons	9,861
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 49,361

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,964
Unemployment Compensation Insurance	14,577
FICA Taxes	185,374
Employee Health Insurance	116,549
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 342,464

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
License-City of Chicago	550
Various Subs	788
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,318

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Various	450
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 450

**See instructions.

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.

(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?

(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?

(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? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,000** Line **10**

(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.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **256,086**
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? **No** 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. $ **0** Has any meal income been offset against related costs? ____ Indicate the amount. $ ____

(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. $ ____
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? ____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? ____
g. Does the facility transport residents to and from day training? ____
Indicate the amount of income earned from providing such transportation during this reporting period. $ ____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: ____

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.