

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0035782</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>RREM, Inc. d/b/a Winston Manor Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> 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.	
Address: <u>2155 West Pierce Avenue</u> <u>Chicago</u> <u>60622</u>			
NumberCityZip Code			
County: <u>Cook</u>			
Telephone Number: <u>(773) 252-2066</u> Fax # <u>(773) 252-3688</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>01/01/1990</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☒ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____			

☐ GOVERNMENTAL☐ State☐ County☐ Other _____

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home

0035782 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

180

1		2		3		4	
	Beds at Beginning of Report Period	Licensure Level of Care		Beds at End of Report Period	Licensed Bed Days During Report Period		
1		Skilled (SNF)					1
2		Skilled Pediatric (SNF/PED)					2
3	180	Intermediate (ICF)		180	65,700		3
4		Intermediate/DD					4
5		Sheltered Care (SC)					5
6		ICF/DD 16 or Less					6
7	180	TOTALS		180	65,700		7

B. Census-For the entire report period.

	1	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	58,012	513	277	58,802	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,012	513	277	58,802	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.50%

D. How many bed-hold days during this year were paid by the Department? 1,371 (Do not include bed-hold days in Section B.)

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

N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 01/01/1990

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1989 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011
* 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: 01/01/2011 Ending: 12/31/2011
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	231,918	18,071	9,871	259,860		259,860	25,000	284,860			1
2	Food Purchase		227,478		227,478	(23,887)	203,591	(2,961)	200,630			2
3	Housekeeping	201,914	24,683		226,597		226,597		226,597			3
4	Laundry		8,824		8,824		8,824		8,824			4
5	Heat and Other Utilities			98,272	98,272		98,272	3,670	101,942			5
6	Maintenance	62,916	27,353		90,269		90,269	140,979	231,248			6
7	Other (specify):* Attached Schedule			35,405	35,405		35,405	138	35,543			7
8	TOTAL General Services	496,748	306,409	143,548	946,705	(23,887)	922,818	166,826	1,089,644			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,202,833	32,519	205,347	1,440,699		1,440,699	(10,444)	1,430,255			10
10a	Therapy	25,608			25,608		25,608		25,608			10a
11	Activities	86,589	2,021		88,610		88,610		88,610			11
12	Social Services	111,010		9,436	120,446		120,446		120,446			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,426,040	34,540	217,783	1,678,363		1,678,363	(10,444)	1,667,919			16
	C. General Administration											
17	Administrative			710,268	710,268		710,268	(376,096)	334,172			17
18	Directors Fees											18
19	Professional Services			49,570	49,570		49,570	(310)	49,260			19
20	Dues, Fees, Subscriptions & Promotions			6,644	6,644		6,644	209	6,853			20
21	Clerical & General Office Expenses	87,796		68,021	155,817		155,817	113,653	269,470			21
22	Employee Benefits & Payroll Taxes			433,119	433,119	23,887	457,006	54,174	511,180			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,820	1,820		1,820		1,820			24
25	Other Admin. Staff Transportation			5,579	5,579		5,579	(595)	4,984			25
26	Insurance-Prop.Liab.Malpractice			87,789	87,789		87,789	1,497	89,286			26
27	Other (specify):*											27
28	TOTAL General Administration	87,796		1,362,810	1,450,606	23,887	1,474,493	(207,468)	1,267,025			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,010,584	340,949	1,724,141	4,075,674		4,075,674	(51,086)	4,024,588			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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			19,837	19,837		19,837	57,901	77,738			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			783	783		783	(1)	782			32
33	Real Estate Taxes							207,419	207,419			33
34	Rent-Facility & Grounds			578,419	578,419		578,419	(578,419)				34
35	Rent-Equipment & Vehicles			23,532	23,532		23,532	508	24,040			35
36	Other (specify):*											36
37	TOTAL Ownership			622,571	622,571		622,571	(312,592)	309,979			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			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			98,550	98,550		98,550		98,550			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,010,584	340,949	2,445,262	4,796,795		4,796,795	(363,678)	4,433,117			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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	6,374	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	(3,270)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(955)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(32,450)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,826)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,444)	10		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,112)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(150)	20		28
29	Other-Attach Schedule	(38,789)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (83,622)		\$	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)	(280,056)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (280,056)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (363,678)		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

Report Period Beginning:

Ending:

ID#

0035782

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Trust Fee	\$ (150)	21	1
2	Franchise Tax	(100)	21	2
3	Marketing Costs - Allocated from Mng Company	(612)	20	3
4	Loss on Investment in Hamlin Partnership	(37,927)	43	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
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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	(38,789)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home# 0035782

Report Period Beginning:

01/01/2011

Ending:

12/31/2011**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	25,000	0	0	0	0	0	0	0	0	25,000	1
2	Food Purchase	(3,270)	0	309	0	0	0	0	0	0	0	0	(2,961)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,670	0	0	0	0	0	0	0	0	0	3,670	5
6	Maintenance	0	1,111	139,868	0	0	0	0	0	0	0	0	140,979	6
7	Other (specify):*	0	138	0	0	0	0	0	0	0	0	0	138	7
8	TOTAL General Services	(3,270)	4,919	165,177	0	0	0	0	0	0	0	0	166,826	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	(10,444)	0	0	0	0	0	0	0	0	0	0	(10,444)	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	(10,444)	0	0	0	0	0	0	0	0	0	0	(10,444)	16
	C. General Administration													
17	Administrative	0	0	(376,096)	0	0	0	0	0	0	0	0	(376,096)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,826)	0	1,516	0	0	0	0	0	0	0	0	(310)	19
20	Fees, Subscriptions & Promotions	(762)	851	120	0	0	0	0	0	0	0	0	209	20
21	Clerical & General Office Expenses	(34,812)	3,126	145,339	0	0	0	0	0	0	0	0	113,653	21
22	Employee Benefits & Payroll Taxes	0	54,174	0	0	0	0	0	0	0	0	0	54,174	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	(955)	300	60	0	0	0	0	0	0	0	0	(595)	25
26	Insurance-Prop.Liab.Malpractice	0	1,497	0	0	0	0	0	0	0	0	0	1,497	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(38,355)	59,948	(229,061)	0	0	0	0	0	0	0	0	(207,468)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,069)	64,867	(63,884)	0	0	0	0	0	0	0	0	(51,086)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	6,374	0	51,527	0	0	0	0	0	0	0	0	57,901	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	(1)	0	0	0	0	0	0	0	0	(1)	32
33	Real Estate Taxes	0	0	207,419	0	0	0	0	0	0	0	0	207,419	33
34	Rent-Facility & Grounds	0	0	(578,419)	0	0	0	0	0	0	0	0	(578,419)	34
35	Rent-Equipment & Vehicles	0	508	0	0	0	0	0	0	0	0	0	508	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	6,374	508	(319,474)	0	0	0	0	0	0	0	0	(312,592)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(37,927)	0	37,927	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(37,927)	0	37,927	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(83,622)	65,375	(345,431)	0	0	0	0	0	0	0	0	(363,678)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	75.70	Balmoral Home, Inc.	Chicago	Nivram Mngt, Inc.	Lincolnwood	Management
Joseph Mermelstein	24.30	Chicago Ridge Nursing Center	Chicago Ridge	Pierce Bldg Partner	Lincolnwood	Lessor

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	25	Auto Expense	\$	Nivram Management, Inc.	50.00%	\$ 300	\$ 300	1
2	V	20	Advertising		Nivram Management, Inc.	50.00%	612	612	2
3	V	21	Bank Charges		Nivram Management, Inc.	50.00%	169	169	3
4	V	6	Repairs and Maintenance		Nivram Management, Inc.	50.00%	1,111	1,111	4
5	V	5	Utilities		Nivram Management, Inc.	50.00%	3,670	3,670	5
6	V	21	Delivery Expense		Nivram Management, Inc.	50.00%	453	453	6
7	V	21	Office Expense		Nivram Management, Inc.	50.00%	2,504	2,504	7
8	V	20	Dues and Subscriptions		Nivram Management, Inc.	50.00%	239	239	8
9	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	37,342	37,342	9
10	V	26	Insurance		Nivram Management, Inc.	50.00%	1,497	1,497	10
11	V	22	Health Insurance		Nivram Management, Inc.	50.00%	16,832	16,832	11
12	V	7	Scavenger		Nivram Management, Inc.	50.00%	138	138	12
13	V	35	Equipment Rental		Nivram Management, Inc.	50.00%	508	508	13
14	Total			\$			\$ 65,375	\$ * 65,375	14

* 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# 0035782Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Sales Taxes	\$	Nivram Management, Inc.	50.00%	\$ 309	\$ 309 15
16	V	21 Postage		Nivram Management, Inc.	50.00%	271	271 16
17	V	19 Legal and Accounting		Nivram Management, Inc.	50.00%	1,516	1,516 17
18	V	20 Licenses and Permits		Nivram Management, Inc.	50.00%	120	120 18
19	V	25 Travel		Nivram Management, Inc.	50.00%	60	60 19
20	V	30 Depreciation		Nivram Management, Inc.	50.00%	621	621 20
21	V	21 Data Processing		Nivram Management, Inc.	50.00%	449	449 21
22	V	21 Telephone		Nivram Management, Inc.	50.00%	2,268	2,268 22
23	V	6 Plant Supervisor Salary		Nivram Management, Inc.	50.00%	139,868	139,868 23
24	V	17 Asst. Administrator		Nivram Management, Inc.	50.00%	209,802	209,802 24
25	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	38,187	38,187 25
26	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	25,000	25,000 26
27	V	17 Administrative Salaries		Nivram Management, Inc.	50.00%	46,635	46,635 27
28	V	17 Administrator Salary		Nivram Management, Inc.	50.00%	77,735	77,735 28
29	V	21 Clerical Salaries		Nivram Management, Inc.	50.00%	102,052	102,052 29
30	V	17 Management Fees	710,268	Nivram Management, Inc.	50.00%		(710,268) 30
31	V						
32	V	43 Loss from Hamlin Investments		Pierce Buildng Partnership		37,927	37,927 32
33	V	30 Depreciation		Pierce Buildng Partnership		50,906	50,906 33
34	V	33 Real Estate Taxes		Pierce Buildng Partnership		207,419	207,419 34
35	V	21 State Income Taxes		Pierce Buildng Partnership		2,112	2,112 35
36	V	32 Interest Income	1	Pierce Buildng Partnership			(1) 36
37	V	34 Rental Income	578,419	Pierce Buildng Partnership			(578,419) 37
38	V						
39	Total		\$ 1,288,688			\$ 943,257	\$ * (345,431) 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 I # 0035782 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	0.00	50,000	13	33.33	Salary	\$ 25,000	17-7	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	50,000	6	31.58	Salary	25,000	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	75.70	305,378	5	28.85	Salary	139,868	6-7	3
4	Doreen Mermelstein	Office Manager	Support	0.00	76,373	13	33.33	Salary	38,187	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	517,510	8	28.85	Salary	209,802	17-7	6
7	Joseph Mermelstein	Administrative	Administrative	24.30	53,365	3	28.85	Salary	21,635	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 459,492		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:

01/01/2011Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization

Nivram Management, Inc.

Street Address

6500 N. Hamlin Avenue

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 679-7484

Fax Number

(847) 679-7494

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	25	Auto Expense	Resident Beds	624	3	\$ 1,041	\$ 180	\$ 300	1
2	20	Advertising	Resident Beds	624	3	2,123	180	612	2
3	21	Bank Charges	Resident Beds	624	3	585	180	169	3
4	6	Repairs and Maintenance	Resident Beds	624	3	3,852	180	1,111	4
5	5	Utilities	Resident Beds	624	3	12,724	180	3,670	5
6	21	Delivery Expense	Resident Beds	624	3	1,572	180	453	6
7	21	Office Expense	Resident Beds	624	3	8,680	180	2,504	7
8	20	Dues and Subscriptions	Resident Beds	624	3	829	180	239	8
9	22	Payroll Taxes	Resident Beds	624	3	129,453	180	37,342	9
10	26	Insurane	Resident Beds	624	3	5,189	180	1,497	10
11	22	Health Insurance	Resident Beds	624	3	58,350	180	16,832	11
12	7	Scavenger	Resident Beds	624	3	480	180	138	12
13	35	Equipment Rental	Resident Beds	624	3	1,760	180	508	13
14	2	Sales Taxes	Resident Beds	624	3	1,070	180	309	14
15	21	Postage	Resident Beds	624	3	941	180	271	15
16	19	Legal and Accounting	Resident Beds	624	3	5,255	180	1,516	16
17	20	Licenses & Permits	Resident Beds	624	3	415	180	120	17
18	25	Travel	Resident Beds	624	3	209	180	60	18
19	30	Depreciation	Resident Beds	624	3	2,153	180	621	19
20	21	Data Processing	Resident Beds	624	3	1,558	180	449	20
21	21	Telephone	Resident Beds	624	3	7,863	180	2,268	21
22									22
23									23
24									24
25	TOTALS					\$ 246,102	\$	\$ 70,989	25

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home # 0035782 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	Plant Supervisor Salary	Direct Cost	1	1	\$ 139,868	\$ 139,868	1	\$ 139,868	1
2	17	Asst. Administrator Salary	Direct Cost	1	1	209,802	209,802	1	209,802	2
3	21	Office Manager Salary	Direct Cost	1	1	38,187	38,187	1	38,187	3
4	1	Food Service Supervisor Salary	Direct Cost	1	1	25,000	25,000	1	25,000	4
5	17	Administrative Salaries	Direct Cost	1	1	46,635	46,635	1	46,635	5
6	17	Administrator Salary	Direct Cost	1	1	77,735	77,735	1	77,735	6
7	21	Clerical Salaries	Direct Cost	1	1	102,052	102,052	1	102,052	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 639,279	\$ 639,279		\$ 639,279	25

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	Parkway Bank		X	Line of Credit	n/a	11/25/11	243,000	18,000	12/01/12	0.0325	783	6							
7													7						
8													8						
9	TOTAL Facility Related						\$ 243,000	\$ 18,000				\$ 783	9						
	B. Non-Facility Related*																		
10	Interest Income											(1)	10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$	\$				\$ (1)	14						
15	TOTALS (line 9+line14)						\$ 243,000	\$ 18,000				\$ 782	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	196,000	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.)			\$	198,419	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,419	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	205,000	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.			\$	207,419	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	212,596	8	
		2007	210,326	9	
		2008	212,436	10	
		2009	190,141	11	
		2010	198,419	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 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 Sanford B. Alper
TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>17-06-106-0001-0000</u>	<u>Nursing Home</u>	\$ <u>198,418.76</u>	\$ <u>198,418.76</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>198,418.76</u>	\$ <u>198,418.76</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

A. Square Feet: 59,192

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	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:

01/01/2011 Ending:

12/31/2011

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	\$ 48,788	31.5	\$ 48,788	\$	\$ 1,079,536	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System			1990	9,200	292	31.5	292		6,388	9
10	Interior Improvements			1990	32,039	1,018	31.5	1,018		21,925	10
11	Elevator			1990	5,300	168	31.5	168		3,605	11
12	Tiling & Lobby Office			1990	10,143	321	31.5	321		6,854	12
13	Building Improvements			1991	3,230	103	31.5	103		2,110	13
14	Building Improvements			1991	4,806	153	31.5	153		3,123	14
15	Tiles			1991	11,906	377	31.5	377		7,572	15
16	Radiator Cover			1992	12,400	394	31.5	394		7,798	16
17	Electrical Work			1992	3,500	111	31.5	111		2,188	17
18	Building Improvements			1993	21,476	550	39	550		10,118	18
19	Building Improvements			1995	34,754	891	39	891		14,740	19
20	Flooring & Tile			1996	5,355	138	39	138		2,130	20
21	Generator			1996	35,589	913	39	913		14,188	21
22	Air Conditioner			1996	16,511	423	39	423		6,575	22
23	Alarm System			1996	3,744	96	39	96		1,492	23
24	Roof			1996	1,200	31	39	31		482	24
25	Hot Water Heater			1996	2,900	74	39	74		1,150	25
26	Smoke Eater			1993	4,600		10			4,600	26
27	Air Conditioner			1993	2,550		10			2,550	27
28	Carpet			1993	3,527		10			3,527	28
29	Boiler			1993	3,600		10			3,600	29
30	Air Conditioner			1994	5,122		10			5,122	30
31	Hot Water Heater			1995	4,160		10			4,160	31
32	Air Conditioner			1995	2,816		10			2,816	32
33	Glass			1995	647		10			647	33
34	Roof			1997	21,350	547	39	547		8,143	34
35	Phone System			1997	13,666	351	39	351		5,182	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:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Electrical Work	1997	\$ 49,685	\$ 1,274	39	\$ 1,274	\$	\$ 18,633	37
38	Central Air Conditioning	1997	35,499	910	39	910		13,312	38
39	New Office Construction	1997	4,442	114	39	114		1,666	39
40	Boiler Insulation	1997	29,412	754	39	754		11,029	40
41	Fire Alarm & Sprinkler	1997	2,475	63	39	63		928	41
42	Doors & Construction	1997	8,190	210	39	210		3,001	42
43	Plumbing - Toilets & Pipes	1997	4,719	121	39	121		1,739	43
44	Roof	1998	3,900	100	39	100		1,388	44
45	HVAC Work	1998	2,700	69	39	69		954	45
46	Doors & Construction	1998	2,729	69	39	69		925	46
47	Time Clock	1998	5,245	135	39	135		1,821	47
48	Air Conditioner	1998	777	20	39	20		270	48
49	Phone System	1998	1,283	33	39	33		451	49
50	Door	1999	2,500	64	39	64		782	50
51	Fire Damper	1999	1,783	45	39	45		565	51
52	Water System	1999	6,000	154	39	154		1,866	52
53	Door Construction	1999	2,500	64	39	64		782	53
54	Kitchen and Tiling	1999	10,250	262	39	262		3,362	54
55	New Windows	2001	1,300	33	39	33		331	55
56	Doors & Frame	2001	2,025	53	39	53		529	56
57	Electric Wiring	2001	443	11	39	11		111	57
58	Wall Repair	2001	1,000	26	39	26		260	58
59	Roof Repair	2003	1,150	15	39	15		699	59
60	Brick Paver	2004	40,000	1,026	39	1,026		7,350	60
61	Tuckpointing	2004	23,518	603	39	603		4,472	61
62	Building Improvement from Building Partnership	1995	74,705	2,118	39	2,118		39,595	62
63	Bathroom Remodeling	2005	5,125	132	39	132		820	63
64	Pump	2005	2,600	66	39	66		439	64
65	Water Heater	2005	7,400	190	39	190		1,155	65
66	Elevator Machine Room	2006	41,767	1,071	39	1,071		5,355	66
67	Boiler Insulation	2006	32,500	833	39	833		4,305	67
68	Symmetry Construction	2006	5,500	141	39	141		740	68
69	Kitchen Fire Safety System	2006	1,600	41	39	41		210	69
70	TOTAL (lines 4 thru 69)		\$ 2,227,645	\$ 66,559		\$ 66,559	\$	\$ 1,362,166	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:

01/01/2011 Ending: 12/31/2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,227,645	\$ 66,559		\$ 66,559	\$	\$ 1,362,166	1
2 Elevator Recall System	2006	4,500	116	39	116		577	2
3 Wireless Temperature Control	2006	3,500	89	39	89		456	3
4 Pushbutton Lock	2006	380	10	39	10		50	4
5 Roof	2006	7,100	182	39	182		910	5
6 Boiler	2007	26,890	690	39	690		3,275	6
7 Elevator Equipment	2007	8,171	209	39	209		944	7
8 Power Flame Gas Burner	2007	7,000	180	39	180		740	8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,285,186	\$ 68,035		\$ 68,035	\$	\$ 1,369,118	34

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

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	\$ 42,019	\$ 1,343	\$ 8,404	\$ 7,061	5	\$ 23,597	71
72	Current Year Purchases	1,235	1,235	247	(988)	5	247	72
73	Fully Depreciated Assets	515,448				5	515,448	73
74	Management Company		621	621				74
75	TOTALS	\$ 558,702	\$ 3,199	\$ 9,272	\$ 6,073		\$ 539,292	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	2001 Ford Taurus	2006	\$ 2,245	\$ 130	\$ 431	\$ 301		\$ 1,854
77									
78									
79									
80	TOTALS			\$ 2,245	\$ 130	\$ 431	\$ 301		\$ 1,854

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 2,951,133	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 71,364	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 77,738	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 6,374	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 1,910,264	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☒ NO

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

**

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

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms: Annual Lease
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 3,082
- Description: Ice Maker - \$750; Copier - \$1,824; Copier - Mng Company - \$508
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	See Attached Schedule			20,958	18
19					19
20					20
21	TOTAL		\$	\$ 20,958	21

10. Effective dates of current rental agreement:

Beginning 01/01/2011

Ending 12/31/2011

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,583	\$ 9,908	1
2	Cash-Patient Deposits	21,651	21,651	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,830,760	1,830,760	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,696	55,696	6
7	Other Prepaid Expenses	24,237	24,237	7
8	Accounts Receivable (owners or related parties)	43,217	38,011	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,985,144	\$ 1,980,263	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,000	13
14	Buildings, at Historical Cost		1,536,832	14
15	Leasehold Improvements, at Historical Cost	646,655	721,360	15
16	Equipment, at Historical Cost	560,943	560,943	16
17	Accumulated Depreciation (book methods)	(775,058)	(1,854,602)	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) <u>Deposits</u>	500	500	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 433,040	\$ 1,070,033	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,418,184	\$ 3,050,296	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 68,828	\$ 68,828	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,651	21,651	28
29	Short-Term Notes Payable	18,000	18,000	29
30	Accrued Salaries Payable	38,098	38,098	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		205,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		2,112	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	4,701,528	4,701,528	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,848,105	\$ 5,055,217	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)	\$ 4,848,105	\$ 5,055,217	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,429,921)	\$ (2,004,921)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,418,184	\$ 3,050,296	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,955,544)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,955,544)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	925,623	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	(400,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 525,623	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,429,921)	24 *

* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,692,228	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,692,228	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***	5,468	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,468	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	3,500	28
28a	<u>Miscellaneous Income</u>	21,499	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,999	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,722,695	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	946,705	31
32	Health Care	1,678,363	32
33	General Administration	1,450,606	33
	B. Capital Expense		
34	Ownership	622,571	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,796,795	40
41	Income before Income Taxes (line 30 minus line 40)**	925,900	41
42	Income Taxes	(277)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 925,623	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

		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	2,008	1,780	\$ 72,098	\$ 40.50	1
2	Assistant Director of Nursing	1,325	1,437	39,204	27.28	2
3	Registered Nurses	19,242	19,976	428,355	21.44	3
4	Licensed Practical Nurses	1,987	1,776	37,545	21.14	4
5	CNAs & Orderlies	48,839	53,121	618,212	11.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,494	1,738	25,608	14.73	8
9	Activity Director	1,958	2,166	24,843	11.47	9
10	Activity Assistants	5,830	6,203	61,746	9.95	10
11	Social Service Workers	8,778	9,191	111,010	12.08	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,162	39,841	18.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,575	19,107	192,077	10.05	15
16	Dishwashers					16
17	Maintenance Workers	4,109	4,397	62,916	14.31	17
18	Housekeepers	18,503	20,095	201,914	10.05	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,319	8,708	87,796	10.08	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	798	814	7,419	9.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,727	152,671	\$ 2,010,584 *	\$ 13.17	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 9,871	1-3	35
36	Medical Director	O	3,000	9-3	36
37	Medical Records Consultant	N	2,168	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	1,487	10-3	39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	9,436	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,962		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7,748	\$ 201,692	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7,748	\$ 201,692		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
			\$	Workers' Compensation Insurance		\$ 74,749	IDPH License Fee	\$
				Unemployment Compensation Insurance		40,502	Advertising: Employee Recruitment	2,752
				FICA Taxes		149,959	Health Care Worker Background Check	
				Employee Health Insurance		142,680	(Indicate # of checks performed)	
				Employee Meals		23,887	Patient Background Checks	37
				Illinois Municipal Retirement Fund (IMRF)*			Attached Schedule	3,372
				Union Pension		22,953	Yellow Pages Advertising	150
				Chicago Head Tax		2,276	Allocation from Management Company	971
				Allocation from Management Company		54,174	Allocation from Management Company	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
Management Fees			\$ 710,268				Non-allowable advertising	(612)
							Yellow page advertising	(150)
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 710,268				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,853
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Kessler, Orlean, Silver & Co.	Accounting		\$ 17,520				Out-of-State Travel	\$
Laner, Muchin, Dombrow, Becker	Legal		2,794					
Polsinelli Shugart PC	Legal		6,555					
Brown Undell Pomerantz	Legal		2,500				In-State Travel	
Innovative LTC Solutions	Billing Service		6,485					
Personnel Planners	U/C Consultant		1,215					
E Health Data Solutions	Computer		4,531					
Health Data System, Inc.	Computer		1,886				Seminar Expense	1,820
Accu-Med Services, Inc.	Computer		2,640					
Automatic Data Processing	Payroll Processing		2,812					
Medifax-EDI, LLC	Computer		632					
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	\$ 1,820

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

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

Facility Name & ID Number RREM, Inc. d/b/a Winston Manor Nursing Home	STATE OF ILLINOIS # 0035782	Report Period Beginning: 01/01/2011	Ending: 12/31/2011	Page 23
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 98,550
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 23,887 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees