

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0035782 Facility Name: Winston Manor Cnv & Nursing Address: 2155 West Pierce Chicago 60622 County: Cook Telephone Number: (773) 252-2066 Fax #: (773) 252-3688 HFS ID Number: Date of Initial License for Current Owners: Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Sanford B. Alper Telephone Number: (847) 580-4100 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 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) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) Sanford B. Alper Director (Firm Name & Address) Kessler, Orlean, Silver & Company, P.C. 1101 Lake Cook Road, Suite C, Deerfield IL 60015 (Telephone) (847) 580-4100 Fax #: (847) 580-4199 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Winston Manor Cnv & Nursing

0035782 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 <u>180</u>					
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	<u>180</u>	Intermediate (ICF)	<u>180</u>	<u>65,880</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>180</u>	TOTALS	<u>180</u>	<u>65,880</u>	7

B. Census-For the entire report period.					
	1 Level of Care	2 3 4 5 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	<u>51,633</u>	<u>242</u>	<u>155</u>	<u>52,030</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>51,633</u>	<u>242</u>	<u>155</u>	<u>52,030</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.98%

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

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

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

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

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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2016 Ending: 12/31/2016
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	289,210	15,032	10,413	314,655		314,655		314,655			1
2	Food Purchase		243,040		243,040	(31,034)	212,006	(303)	211,703			2
3	Housekeeping	241,352	29,054		270,406		270,406		270,406			3
4	Laundry		11,182		11,182		11,182		11,182			4
5	Heat and Other Utilities			121,572	121,572		121,572	2,716	124,288			5
6	Maintenance	47,100	42,757		89,857		89,857	27,999	117,856			6
7	Other (specify):* Attached Schedule			28,475	28,475		28,475	128	28,603			7
8	TOTAL General Services	577,662	341,065	160,460	1,079,187	(31,034)	1,048,153	30,540	1,078,693			8
	B. Health Care and Programs											
9	Medical Director			2,500	2,500		2,500		2,500			9
10	Nursing and Medical Records	1,080,339	66,814	405,749	1,552,902		1,552,902		1,552,902			10
10a	Therapy	32,917		272	33,189		33,189		33,189			10a
11	Activities	57,568	8,415		65,983		65,983		65,983			11
12	Social Services	100,659		7,344	108,003		108,003		108,003			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,271,483	75,229	415,865	1,762,577		1,762,577		1,762,577			16
	C. General Administration											
17	Administrative			429,775	429,775		429,775	(218,655)	211,120			17
18	Directors Fees											18
19	Professional Services			79,149	79,149		79,149	8,240	87,389			19
20	Dues, Fees, Subscriptions & Promotions			14,980	14,980		14,980	1,491	16,471			20
21	Clerical & General Office Expenses	108,829	10,035	40,788	159,652		159,652	81,793	241,445			21
22	Employee Benefits & Payroll Taxes			329,148	329,148	31,034	360,182	43,698	403,880			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,723	1,723		1,723	804	2,527			24
25	Other Admin. Staff Transportation			9,006	9,006		9,006	(1,332)	7,674			25
26	Insurance-Prop.Liab.Malpractice			89,275	89,275		89,275	1,897	91,172			26
27	Other (specify):*											27
28	TOTAL General Administration	108,829	10,035	993,844	1,112,708	31,034	1,143,742	(82,064)	1,061,678			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,957,974	426,329	1,570,169	3,954,472		3,954,472	(51,524)	3,902,948			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			33,285	33,285		33,285	212,733	246,018			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							197,097	197,097			33
34	Rent-Facility & Grounds			485,674	485,674		485,674	(485,674)				34
35	Rent-Equipment & Vehicles			25,354	25,354		25,354	234	25,588			35
36	Other (specify):*											36
37	TOTAL Ownership			544,313	544,313		544,313	(75,610)	468,703			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,847	1,847		1,847		1,847			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			414,696	414,696		414,696		414,696			42
43	Other (specify):*							13,664	13,664			43
44	TOTAL Special Cost Centers			416,543	416,543		416,543	13,664	430,207			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,957,974	426,329	2,531,025	4,915,328		4,915,328	(113,470)	4,801,858			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	149,488	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	(303)	2		13
14	Non-Care Related Interest	2	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,458)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,140)	21		18
19	Entertainment				19
20	Contributions	(34,025)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,886)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,280)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(481)	20		28
29	Other-Attach Schedule Attached Schedule	(1,336)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 104,581		\$	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)	(218,051)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (218,051)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (113,470)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Trust Fee	\$ (325)	21	1
2	Franchise Tax	(100)	21	2
3	Entertainment (Management Company)	(564)	21	3
4	Penalties (Management Company)	(42)	21	4
5	Sales Taxes (Management Company)	(305)	2	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	(1,336)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winston Manor Cnv & Nursing# 0035782

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(608)	0	305	0	0	0	0	0	0	0	0	(303)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,716	0	0	0	0	0	0	0	0	0	2,716	5
6	Maintenance	0	1,853	26,146	0	0	0	0	0	0	0	0	27,999	6
7	Other (specify):*	0	0	128	0	0	0	0	0	0	0	0	128	7
8	TOTAL General Services	(608)	4,569	26,579	0	0	0	0	0	0	0	0	30,540	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	(218,655)	0	0	0	0	0	0	0	0	(218,655)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,886)	3,938	969	6,219	0	0	0	0	0	0	0	8,240	19
20	Fees, Subscriptions & Promotions	(481)	1,805	167	0	0	0	0	0	0	0	0	1,491	20
21	Clerical & General Office Expenses	(39,476)	1,997	119,193	79	0	0	0	0	0	0	0	81,793	21
22	Employee Benefits & Payroll Taxes	0	0	43,698	0	0	0	0	0	0	0	0	43,698	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	804	0	0	0	0	0	0	0	0	804	24
25	Other Admin. Staff Transportation	(1,458)	103	23	0	0	0	0	0	0	0	0	(1,332)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,897	0	0	0	0	0	0	0	0	1,897	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(44,301)	7,843	(51,904)	6,298	0	0	0	0	0	0	0	(82,064)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(44,909)	12,412	(25,325)	6,298	0	0	0	0	0	0	0	(51,524)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	149,488	252	0	62,993	0	0	0	0	0	0	0	212,733	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	2	0	0	(2)	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	197,097	0	0	0	0	0	0	0	197,097	33
34	Rent-Facility & Grounds	0	0	(473,246)	(12,428)	0	0	0	0	0	0	0	(485,674)	34
35	Rent-Equipment & Vehicles	0	234	0	0	0	0	0	0	0	0	0	234	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	149,490	486	(473,246)	247,660	0	0	0	0	0	0	0	(75,610)	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	13,664	0	0	0	0	0	0	0	0	13,664	43
44	TOTAL Special Cost Centers	0	0	13,664	0	0	0	0	0	0	0	0	13,664	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	104,581	12,898	(484,907)	253,958	0	0	0	0	0	0	0	(113,470)	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
<u>Marvin Mermelstein</u>	<u>75.70</u>	<u>Balmoral Home, Inc.</u>	<u>Chicago</u>	<u>Nivram Mngt, Inc.</u>	<u>Lincolnwood</u>	<u>Management</u>
<u>Joseph Mermelstein</u>	<u>24.30</u>	<u>Chicago Ridge Nursing Center</u>	<u>Chicago Ridge</u>	<u>Pierce Bldg Partner</u>	<u>Lincolnwood</u>	<u>Lessor</u>
		<u>Central Home, Inc.</u>	<u>Chicago</u>			

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	19	<u>Professional Fees</u>	\$	<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>\$ 3,938</u>	<u>\$ 3,938</u>	1
2	V	20	<u>Advertising</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>182</u>	<u>182</u>	2
3	V	25	<u>Auto Expense</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>103</u>	<u>103</u>	3
4	V	21	<u>Bank Charges</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>91</u>	<u>91</u>	4
5	V	5	<u>Utilities</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>2,716</u>	<u>2,716</u>	5
6	V	6	<u>Repairs & Maintenance</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>1,853</u>	<u>1,853</u>	6
7	V	21	<u>Postage & Delivery</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>799</u>	<u>799</u>	7
8	V	30	<u>Depreciation</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>252</u>	<u>252</u>	8
9	V	20	<u>Dues & Subscriptions</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>1,623</u>	<u>1,623</u>	9
10	V	21	<u>Meals & Entertainment</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>564</u>	<u>564</u>	10
11	V	35	<u>Equipment Rental</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>234</u>	<u>234</u>	11
12	V	21	<u>Furnishing Supplies</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>535</u>	<u>535</u>	12
13	V	21	<u>Housekeeping Supplies</u>		<u>Nivram Management, Inc.</u>	<u>100.00%</u>	<u>8</u>	<u>8</u>	13
14	Total			\$			<u>\$ 12,898</u>	<u>\$ * 12,898</u>	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ 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	26	Insurance	\$	Nivram Management, Inc.		\$ 1,897	\$ 1,897	15
16	V	20	Marketing		Nivram Management, Inc.		41	41	16
17	V	21	Office Expense		Nivram Management, Inc.		12,176	12,176	17
18	V	22	Health Insurance		Nivram Management, Inc.		13,255	13,255	18
19	V	21	Miscellaneous		Nivram Management, Inc.		901	901	19
20	V	21	Penalties		Nivram Management, Inc.		42	42	20
21	V	34	Rent Expense		Nivram Management, Inc.		12,428	12,428	21
22	V	2	Sales Taxes		Nivram Management, Inc.		305	305	22
23	V	7	Scavenger		Nivram Management, Inc.		128	128	23
24	V	24	Seminars		Nivram Management, Inc.		804	804	24
25	V	22	Payroll Taxes		Nivram Management, Inc.		30,443	30,443	25
26	V	21	Telephone		Nivram Management, Inc.		1,508	1,508	26
27	V	25	Travel		Nivram Management, Inc.		23	23	27
28	V	20	Licenses & Permits		Nivram Management, Inc.		126	126	28
29	V	19	Outside Labor		Nivram Management, Inc.		969	969	29
30	V	17	Management Fees	429,775	Nivram Management, Inc.			(429,775)	30
31	V	6	Plant Supervisor Salary		Nivram Management, Inc.		26,146	26,146	31
32	V	17	Asst. Supervisor Salary		Nivram Management, Inc.		39,218	39,218	32
33	V	21	Office Manager Salary		Nivram Management, Inc.		28,640	28,640	33
34	V	17	Administrative Salary		Nivram Management, Inc.		65,535	65,535	34
35	V	17	Administrator Salary		Nivram Management, Inc.		106,367	106,367	35
36	V	21	Clerical Salary		Nivram Management, Inc.		75,926	75,926	36
37	V	34	Rental Income	485,674	Pierce Building Partnership			(485,674)	37
38	V	43	Loss from Investments		Pierce Building Partnership		13,664	13,664	38
39	Total			\$ 915,449			\$ 430,542	\$ * (484,907)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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	30	Depreciation	\$	Pierce Building Partnership	100.00%	\$ 58,576	\$ 58,576	15
16	V	19	Legal Fees		Pierce Building Partnership	100.00%	4,692	4,692	16
17	V	33	Property Taxes		Pierce Building Partnership	100.00%	188,674	188,674	17
18	V	34	Rental Income	12,428	Hamlin & Arthur Partnership	100.00%		(12,428)	18
19	V	32	Interest Income	2	Hamlin & Arthur Partnership	100.00%		(2)	19
20	V	21	Bank Fees		Hamlin & Arthur Partnership	100.00%	79	79	20
21	V	30	Depreciation Expense		Hamlin & Arthur Partnership	100.00%	4,417	4,417	21
22	V	19	Legal Fees		Hamlin & Arthur Partnership	100.00%	1,527	1,527	22
23	V	33	Real Estate Taxes		Hamlin & Arthur Partnership	100.00%	8,423	8,423	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 12,430			\$ 266,388	\$ * 253,958	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: 01/01/2016 Ending: 12/31/2016

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	150,000	10	25.00	Salary	\$ 50,000	17-7	1
2	Marvin Mermelstein	Plant Supervisor	Support	75.70	100,079	4	20.71	Salary	26,146	6-7	2
3	Doreen Mermelstein	Office Manager	Support	0.00	85,920	10	25.00	Salary	28,640	21-7	3
4	Marvin Mermelstein	Asst. Administrator	Administrative	See above	150,119	6	20.71	Salary	39,218	17-7	4
5	Joseph Mermelstein	Administrative	Administrative	24.30	59,465	2	20.71	Salary	15,535	17-7	5
6	Daniel Mermelstein	Clerical	Support	0.00	3,171	1.5	20.71	Salary	829	21-7	6
7	Gavriel Mermelstein	Clerical	Support	0.00	3,171	1.5	20.71	Salary	829	21-7	7
8	Joshua Mermelstein	Clerical	Support	0.00	7,493	2.5	20.71	Salary	1,957	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 163,154		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:

01/01/2016Ending: 2/31/2016

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

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	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
Line Reference									
1	19	Professional Fees	Resident Beds	869	4	\$ 19,014	\$ 180	\$ 3,938	1
2	20	Advertising	Resident Beds	869	4	881	180	182	2
3	25	Auto Expense	Resident Beds	869	4	496	180	103	3
4	21	Bank Charges	Resident Beds	869	4	438	180	91	4
5	5	Utilities	Resident Beds	869	4	13,112	180	2,716	5
6	6	Repairs & Maintenance	Resident Beds	869	4	8,945	180	1,853	6
7	21	Postage & Delivery	Resident Beds	869	4	3,855	180	799	7
8	30	Depreciation	Resident Beds	869	4	1,215	180	252	8
9	20	Dues & Subscriptions	Resident Beds	869	4	7,837	180	1,623	9
10	21	Meals & Entertainment	Resident Beds	869	4	2,723	180	564	10
11	35	Equipment Rental	Resident Beds	869	4	1,130	180	234	11
12	21	Furnishing Supplies	Resident Beds	869	4	2,583	180	535	12
13	21	Housekeeping Supplies	Resident Beds	869	4	37	180	8	13
14	26	Insurance	Resident Beds	869	4	9,158	180	1,897	14
15	20	Marketing	Resident Beds	869	4	200	180	41	15
16	21	Office Expense	Resident Beds	869	4	58,782	180	12,176	16
17	22	Health Insurance	Resident Beds	869	4	63,991	180	13,255	17
18	21	Miscellaneous	Resident Beds	869	4	4,352	180	901	18
19	21	Penalties	Resident Beds	869	4	201	180	42	19
20	34	Rent Expense	Resident Beds	869	4	60,000	180	12,428	20
21	2	Sales Taxes	Resident Beds	869	4	1,472	180	305	21
22	7	Scavenger	Resident Beds	869	4	619	180	128	22
23	24	Seminars	Resident Beds	869	4	3,883	180	804	23
24	22	Payroll Taxes	Resident Beds	869	4	146,971	180	30,443	24
25	TOTALS					\$ 411,895	\$	\$ 85,318	25

Facility Name & ID Number Winston Manor Cnv & Nursing# 0035782

Report Period Beginning:

01/01/2016Ending: 2/31/2016

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	21	Telephone	Resident Beds	869	4	\$ 7,282	\$ 180	\$ 1,508	1
2	25	Travel	Resident Beds	869	4	111	180	23	2
3	20	Licenses & Permits	Resident Beds	869	4	608	180	126	3
4	19	Outside Labor	Resident Beds	869	4	4,680	180	969	4
5	6	Plant Supervisor Salary	Direct Cost	1	1	26,146	26,146	1	5
6	17	Asst. Supervisor Salary	Direct Cost	1	1	39,218	39,218	1	6
7	21	Office Manager Salary	Direct Cost	1	1	28,640	28,640	1	7
8	17	Administrative Salary	Direct Cost	1	1	65,535	65,535	1	8
9	17	Administrator Salary	Direct Cost	1	1	106,367	106,367	1	9
10	21	Clerical Salaries	Direct Cost	1	1	75,926	75,926	1	10
11	21	Bank Fees	Resident Beds	869	4	383	180	79	11
12	30	Depreciation	Resident Beds	869	4	21,326	180	4,417	12
13	19	Legal Fees	Resident Beds	869	4	7,372	180	1,527	13
14	33	Real Estate Taxes	Resident Beds	869	4	40,663	180	8,423	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 424,257	\$ 341,832	\$ 358,904	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													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.)

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 2015 report.			\$	229,000	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.)			\$	214,097	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(14,903)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	212,000	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.			\$	197,097	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	230,843	8	
		2012	250,242	9	
		2013	262,440	10	
		2014	267,927	11	
		2015	252,957	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winston Manor Cnv & Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035782

CONTACT PERSON REGARDING THIS REPORT Sandord B. Alper

TELEPHONE (847) 580-4100 FAX #: (847)580-4199

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 17-06-106-001-0000	Nursing Home	\$ 205,674.00	\$ 205,674.00
2. 10-35-325-029-0000	Management Company	\$ 4,426.00	\$ 788.00
3. 10-35-325-015-0000	Management Company	\$ 42,857.00	\$ 7,635.00
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 252,957.00	\$ 214,097.00

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies 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).

N/A

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	180		1989		\$ 1,536,832	\$ 55,841	31.5	\$ 171,216	\$ 115,375	\$ 1,690,748	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System			1990	9,200	515	27.5		(515)	9,200	9
10	Interior Improvements			1990	32,039	515	27.5		(515)	32,039	10
11	Elevator			1990	5,300	516	27.5		(516)	5,300	11
12	Tiling & Lobby Office			1990	10,143	516	27.5		(516)	10,143	12
13	Building Improvements			1991	3,230	725	27.5	774	49	3,230	13
14	Building Improvements			1991	4,806		27.5	105	105	3,744	14
15	Tiles			1991	11,906	579	27.5		(579)	11,906	15
16	Radiator Cover			1992	12,400		27.5	418	418	12,400	16
17	Electrical Work			1992	3,500		27.5	132	132	3,500	17
18	Building Improvements			1993	21,476	781	27.5		(781)	21,476	18
19	Building Improvements			1995	34,754	1,264	27.5	1,264		34,132	19
20	Flooring & Tile			1996	5,355	195	27.5	547	352	5,355	20
21	Generator			1996	35,589	1,294	27.5	3,597	2,303	35,589	21
22	Alarm System			1996	3,744	136	27.5	380	244	3,744	22
23	Roof			1996	1,200	43	27.5	116	73	1,200	23
24	Smoke Eater			1993	4,600		10			4,600	24
25	Air Conditioner			1993	2,550		10			2,550	25
26	Carpet			1993	3,527		10			3,527	26
27	Boiler			1993	3,600		10			3,600	27
28	Air Conditioner			1994	5,122		10			5,122	28
29	Hot Water Heater			1995	4,160		10			4,160	29
30	Air Conditioner			1995	2,816		10			2,816	30
31	Glass			1995	647		10			647	31
32	Roof			1997	21,350	777	27.5	2,835	2,058	21,350	32
33	Phone System			1997	13,666	497	27.5	1,868	1,371	13,666	33
34	Electrical Work			1997	49,685	1,807	27.5	7,176	5,369	49,685	34
35	Central Air Conditioning			1997	35,499	1,291	27.5	5,129	3,838	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:

01/01/2016

Ending:

12/31/2016

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	New Office Construction	1997	\$ 4,442	\$ 162	27.5	\$ 640	\$ 478	\$ 4,442	37
38	Fire Alarm & Sprinkler	1997	2,475	90	27.5	359	269	2,475	38
39	Doors & Construction	1997	8,190	298	27.5	1,728	1,430	5,149	39
40	Plumbing - Toilets & Pipes	1997	4,719	171	27.5	738	567	4,719	40
41	Roof	1998	3,900	142	27.5	700	558	3,900	41
42	HVAC Work	1998	2,700	99	27.5	498	399	2,700	42
43	Door & Construction	1998	2,729	100	27.5	545	445	2,698	43
44	Phone System	1998	1,283	46	27.5	240	194	1,283	44
45	Door	1999	2,500	91	27.5	471	380	2,323	45
46	Fire Damper	1999	1,783	65	27.5	338	273	1,669	46
47	Water System	1999	6,000	218	27.5	1,127	909	5,555	47
48	Door Construction	1999	2,500	91	27.5	471	380	2,323	48
49	Kitchen and Tiling	1999	10,250	373	27.5	1,999	1,626	9,883	49
50	New Windows	2001	1,300		27.5	220	220	1,057	50
51	Doors & Frame	2001	2,025	175	27.5	343	168	1,664	51
52	Electric Wiring	2001	443		27.5	75	75	358	52
53	Wall Repair	2001	1,000		27.5	169	169	819	53
54	Roof Repair	2003	1,150	34	27.5		(34)	1,150	54
55	Brick Paver	2004	40,000	1,454	27.5	5,386	3,932	25,560	55
56	Tuckpointing	2004	23,518	855	27.5	3,230	2,375	15,368	56
57	Building Improvements from Building Partnership	1995	74,705		27.5	1,502	1,502	74,705	57
58	Bathroom Remodeling	2005	5,125	186	27.5	640	454	3,004	58
59	Boiler Insulation	2006	32,500	1,182	27.5	3,679	2,497	17,008	59
60	Symmerty Construction	2006	5,500	200	27.5	627	427	2,903	60
61	Kitchen Fire Safety System	2006	1,600	58	27.5	180	122	832	61
62	Wireless Temperature Control	2006	3,500	127	27.5	502	375	2,315	62
63	Pushbutton Lock	2006	380	14	27.5	43	29	242	63
64	Roof	2006	7,100	258	27.5	791	533	3,647	64
65	Boiler	2007	26,890	978	27.5	2,924	1,946	13,427	65
66	Power Flame Gas Burner	2007	7,000	254	27.5	714	460	3,242	66
67	Fire Alarm	2012	4,300	508	27.5	214	(294)	780	67
68	Doors Project	2012	3,978	144	27.5	198	54	722	68
69	Elevator Improvements	2012	9,000	327	27.5	448	121	1,632	69
70	TOTAL (lines 4 thru 69)		\$ 2,183,181	\$ 75,992		\$ 227,296	\$ 151,304	\$ 2,250,482	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:

01/01/2016 Ending: 12/31/2016

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		\$ 2,183,181	\$ 75,992		\$ 227,296	\$ 151,304	\$ 2,250,482	1
2 Water Heater	2013	5,100	185	27.5	186	1	557	2
3 Relocate Panelboard and Circuities	2014	9,500	345	27.5	346	1	1,037	3
4 A/C System	2014	7,650	278	27.5	278		834	4
5 Pipes & Wires	2014	4,800	174	27.5	175	1	525	5
6 Wiring Upgrade	2014	7,880	287	27.5	286	(1)	811	6
7 Sprinkling Sysyem	2015	3,994	145	27.5	145		290	7
8 Elevator	2015	104,660	3,806	27.5	3,806		5,709	8
9 Water Heater	2015	8,369	304	27.5	304		583	9
10 Fire Service equipment, labor, and testing	2015	22,000	800	27.5	800		867	10
11 Elevator Motor & Break Assembly	2016	19,837	661	27.5	661		661	11
12 Refrigerator Cooler Components	2016	8,500	180	27.5	180		180	12
13 Air Conditioning Unit	2016	20,938	444	27.5	444		444	13
14 Elevator Valve	2016	3,800	69	27.5	69		69	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)		\$ 2,410,209	\$ 83,670		\$ 234,976	\$ 151,306	\$ 2,263,049	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	\$ 17,737	\$ 5,145	\$ 3,327	\$ (1,818)	5-7	\$ 7,432	71
72	Current Year Purchases	3,316	663	663		5	663	72
73	Fully Depreciated Assets	562,756					562,756	73
74	Mng Company & Bld Partn		7,052	7,052				74
75	TOTALS	\$ 583,809	\$ 12,860	\$ 11,042	\$ (1,818)		\$ 570,851	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Facility	Ford Taurus	2006	\$ 2,245	\$	\$	\$	5	\$ 2,245
77									
78									
79									
80	TOTALS			\$ 2,245	\$	\$	\$		\$ 2,245

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)			\$	3,101,263
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	96,530
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	246,018
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	149,488
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,836,145

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: \$ 2,823
- Description: Copier - \$1,689; Ice Maker - \$900, Mng Compay - \$234
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See Attached Schedule		\$	\$ 22,765	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 22,765	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.

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

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
	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	\$ 352,177	\$ 581,545	1
2	Cash-Patient Deposits	46,049	46,049	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	908,824	908,824	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,391	44,391	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	28,917	28,917	8
9	Other(specify): <u>Investments</u>		402,684	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,380,358	\$ 2,012,410	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	771,680	846,385	15
16	Equipment, at Historical Cost	586,051	586,051	16
17	Accumulated Depreciation (book methods)	(943,532)	(2,523,408)	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)	\$ 414,199	\$ 550,860	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,794,557	\$ 2,563,270	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 106,575	\$ 106,575	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,256	43,256	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,939	74,939	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		212,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,259	10,259	35
	Other Current Liabilities(specify):			
36	<u>Attached Schedule</u>	4,665,959	4,665,959	36
37	<u>Due to Related Party</u>	129,513		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,030,501	\$ 5,112,988	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)	\$ 5,030,501	\$ 5,112,988	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,235,944)	\$ (2,549,718)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,794,557	\$ 2,563,270	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,292,913)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,292,913)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	806,969	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	(750,000)	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)	\$ 56,969	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)	\$ (3,235,944)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,712,718	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,712,718	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	98	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	488	19
20	Radiology and X-Ray		20
21	Other Medical Services	176	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 762	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,738	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,738	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	3,500	28
28a	Miscellaneous Income	13,249	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,749	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,732,967	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,079,187	31
32	Health Care	1,762,577	32
33	General Administration	1,112,708	33
	B. Capital Expense		
34	Ownership	544,313	34
	C. Ancillary Expense		
35	Special Cost Centers	1,847	35
36	Provider Participation Fee	414,696	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,915,328	40
41	Income before Income Taxes (line 30 minus line 40)**	817,639	41
42	Income Taxes	(10,670)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 806,969	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

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

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

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

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	1,116	1,316	\$ 49,937	\$ 37.95	1
2	Assistant Director of Nursing	2,566	2,742	74,670	27.23	2
3	Registered Nurses	14,184	14,944	384,772	25.75	3
4	Licensed Practical Nurses	429	437	10,827	24.78	4
5	CNAs & Orderlies	37,979	41,769	524,313	12.55	5
6	CNA Trainees					6
7	Licensed Therapist	1,081	1,125	32,917	29.26	7
8	Rehab/Therapy Aides	1,197	1,309	28,949	22.12	8
9	Activity Director	329	345	4,220	12.23	9
10	Activity Assistants	4,855	5,126	53,348	10.41	10
11	Social Service Workers	6,831	7,138	100,659	14.10	11
12	Dietician					12
13	Food Service Supervisor	1,963	2,179	41,796	19.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,781	22,885	247,414	10.81	15
16	Dishwashers					16
17	Maintenance Workers	2,713	2,929	47,100	16.08	17
18	Housekeepers	19,318	21,382	241,352	11.29	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,318	9,888	108,829	11.01	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	631	639	6,871	10.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,291	136,153	\$ 1,957,974 *	\$ 14.38	34

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	\$ 10,413	1-3	35
36	Medical Director	O	2,500	9-3	36
37	Medical Records Consultant	N			37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	10,581	10-3	39
40	Physical Therapy Consultant	L	272	10a-3	40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E			45
46	Other(specify) Dental	S	1,506	10-3	46
47	Psycho Social		7,344	12-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,616		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 393,662	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ 393,662		53

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

** See instructions.

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		\$ 45,499	IDPH License Fee		\$	
				Unemployment Compensation Insurance		10,477	Advertising: Employee Recruitment		6,778	
				FICA Taxes		148,448	Health Care Worker Background Check			
				Employee Health Insurance		106,503	(Indicate # of checks performed 30)		870	
				Employee Meals		31,034	Patient Background Checks		520	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		1,149	
				Union Pension		18,221	Licenses & Permits		5,182	
				Allocation from Management Company		43,698	Allocation from Management Company		1,972	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Yellow Pages Advertising		481	
B. Administrative - Other							Less: Public Relations Expense		()	
Description			Amount				Non-allowable advertising		()	
Management Fees			\$ 429,775				Yellow page advertising		(481)	
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,471	
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 403,880				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees						
C. Professional Services				Description		Line #	Amount		G. Schedule of Travel and Seminar**	
Vendor/Payee		Type	Amount						Description	Amount
Attached Schedule			\$ 79,149						Out-of-State Travel	\$
									In-State Travel	
									Seminar Expense	1,723
									Allocation from Management Company	804
									Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 79,149	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		TOTAL	\$ 2,527

*** Attach copy of IMRF notifications**

****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. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 414,696
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 benefit on Schedule V. \$ 31,034 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) 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