		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0035782

Facility Name: Winston Manor Cnv Nursing

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mendel S Schneider **Telephone Number:** 847-933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) See Accountant's Report Attached (Date)
(Print Name and Title)
(Firm Name & Address) Mendel S Schneider & Associates CPA PC, 4051 Old Orchard Rd Skokie Illinois 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		1 Medicaid Fee for Service	2 Medicaid MLTSS	3 MMAI Medicaid Primary	4 MMAI Medicare Primary	5 Private Pay	6 Medicare Part A Only	7 Other	8 Total	9
8	SNF									8
9	SNF/PED									9
10	ICF	3,235	34,798	2,882		796			41,711	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,235	34,798	2,882		796			41,711	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 63.49%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/90

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

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter certified beds.
number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	464,993	7,217	8,122	480,332		480,332		480,332			1
2	Food Purchase		289,905		289,905		289,905		289,905			2
3	Housekeeping	337,559	8,582	13,155	359,296		359,296		359,296			3
4	Laundry	45,000	10,420		55,420		55,420		55,420			4
5	Heat and Other Utilities			120,571	120,571		120,571	3,572	124,143			5
6	Maintenance	62,489		71,989	134,478		134,478	3,139	137,617			6
7	Other (specify):*											7
8	TOTAL General Services	910,041	316,124	213,837	1,440,002		1,440,002	6,711	1,446,713			8
	B. Health Care and Programs											
9	Medical Director			2,500	2,500		2,500		2,500			9
10	Nursing and Medical Records	1,805,911	72,352	597,721	2,475,984		2,475,984		2,475,984			10
10a	Therapy											10a
11	Activities	155,133			155,133		155,133		155,133			11
12	Social Services	151,577		14,991	166,568		166,568		166,568			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,112,621	72,352	615,212	2,800,185		2,800,185		2,800,185			16
	C. General Administration											
17	Administrative	209,818		1,109,065	1,318,883		1,318,883	(1,092,749)	226,134			17
18	Directors Fees											18
19	Professional Services			50,647	50,647		50,647	14,569	65,216			19
20	Dues, Fees, Subscriptions & Promotions			20,587	20,587		20,587	(3,036)	17,551			20
21	Clerical & General Office Expenses	109,038	10,387	108,501	227,926		227,926	784,739	1,012,665			21
22	Employee Benefits & Payroll Taxes			397,960	397,960		397,960		397,960			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			356,462	356,462		356,462	3,051	359,513			26
27	Other (specify):* Allocated Benefits							42,665	42,665			27
28	TOTAL General Administration	318,856	10,387	2,043,222	2,372,465		2,372,465	(250,761)	2,121,704			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,341,518	398,863	2,872,271	6,612,652		6,612,652	(244,050)	6,368,602			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Winston Manor Cnv Nursing #0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			68,483	68,483		68,483	(37,980)	30,503			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			3,834	3,834		3,834	272,450	276,284			33
34	Rent-Facility & Grounds			513,039	513,039		513,039	(513,039)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Bad Debt**			4,254	4,254		4,254	(4,254)				36
37	**TOTAL Ownership**			589,610	589,610		589,610	(282,823)	306,787			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			773,247	773,247		773,247		773,247			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			773,247	773,247		773,247		773,247			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,341,518	398,863	4,235,128	7,975,509		7,975,509	(526,873)	7,448,636			45

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

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	(37,980)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,725)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,254)	36		24
25	Fund Raising, Advertising and Promotional	(3,036)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (47,995)		$	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)	(478,878)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (478,878)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (526,873)		37

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

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

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

Winston Manor Cnv Nursing

ID# 0035782

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,572	0	0	0	0	0	0	0	0	3,572	5
6	Maintenance	0	0	3,139	0	0	0	0	0	0	0	0	3,139	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	6,711	0	0	0	0	0	0	0	0	6,711	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	(1,092,749)	0	0	0	0	0	0	0	0	(1,092,749)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	14,569	0	0	0	0	0	0	0	0	14,569	19
20	Fees, Subscriptions & Promotions	(3,036)	0	0	0	0	0	0	0	0	0	0	(3,036)	20
21	Clerical & General Office Expenses	(2,725)	0	787,464	0	0	0	0	0	0	0	0	784,739	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,051	0	0	0	0	0	0	0	0	3,051	26
27	Other (specify):*	0	0	42,665	0	0	0	0	0	0	0	0	42,665	27
28	**TOTAL General Administration**	(5,761)	0	(245,000)	0	0	0	0	0	0	0	0	(250,761)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,761)	0	(238,289)	0	0	0	0	0	0	0	0	(244,050)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 **Report Period Beginning:** 01/01/2025 **Ending:** 12/31/2025

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(37,980)	0	0	0	0	0	0	0	0	0	0	(37,980)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	260,133	12,317	0	0	0	0	0	0	0	0	272,450	33
34	Rent-Facility & Grounds	0	(513,039)	0	0	0	0	0	0	0	0	0	(513,039)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(4,254)	0	0	0	0	0	0	0	0	0	0	(4,254)	36
37	**TOTAL Ownership**	(42,234)	(252,906)	12,317	0	0	0	0	0	0	0	0	(282,823)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(47,995)	(252,906)	(225,972)	0	0	0	0	0	0	0	0	(526,873)	45

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 513,039	Pierce Building Partnership	100.00%	$	$ (513,039)	1
2	V	33	Real Estate Tax		Pierce Building Partnership		260,133	260,133	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 513,039			$ 260,133	$ * (252,906)	14

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

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 1,109,065	Nivram Mgmt Co	100.00%	$	$ (1,109,065)	15
16	V	21	Paroll		Nivram Mgmt Co		384,515	384,515	16
17	V	27	Payroll Taxes		Nivram Mgmt Co		42,665	42,665	17
18	V	33	Real Estate Taxes		Nivram Mgmt Co		12,317	12,317	18
19	V	5	Utilities		Nivram Mgmt Co		3,572	3,572	19
20	V	6	Repairs & Maintenance		Nivram Mgmt Co		3,139	3,139	20
21	V	26	Insurance		Nivram Mgmt Co		3,051	3,051	21
22	V	19	Professional Fees		Nivram Mgmt Co		14,569	14,569	22
23	V	21	Office		Nivram Mgmt Co		29,683	29,683	23
24	V	17	Marvin Mermelstein		Nivram Mgmt Co		16,316	16,316	24
25	V	21	Doreen Mermelstein		Nivram Mgmt Co		2,830	2,830	25
26	V	21	Jacob Mermelstein		Nivram Mgmt Co		112,088	112,088	26
27	V	21	Joel Mermelstein		Nivram Mgmt Co		112,329	112,329	27
28	V	21	Jeffrey Mermelstein		Nivram Mgmt Co		146,019	146,019	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			$ 1,109,065			$ 883,093	$ * (225,972)	39

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

STATE OF ILLINOIS **Ownership Listing-1**

Winston Manor Cnv Nursing

ID# **0035782**

Report Period Beginning: **01/01/2025**

Ending: **12/31/2025**

Perce Bldg

Nivram Mgmt

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Marvin		Mermelstein	Lincolnwood	IL	75.70000	75.70000	100.00000	1
2	Joseph		Mermelstein	Brooklyn	NY	24.30000	24.30000	0.00000	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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67									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

Winston Manor Cnv Nursing

ID# **0035782**

Report Period Beginning: **01/01/2025**

Ending: **12/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
88									88
89									89
90									90
91									91
92									92
93									93
94									94
95									95
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97									97
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101									101
102									102
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137									137
138									138
139									139
140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Central Nursing Home	Chicago			Pierce Bldg Part	Lincolnwood, IL	Bldg Rental	1
2	Balmoral Nursing Home	Chicago			Nivram Mgmt Co	Lincolnwood, IL	Mgmt	2
3	Paul House Health Care center	Chicago						3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marvin Mermelstein		Adm	75.70	51,486	10	25.00	Salary	$ 16,316	17	1
2	Doreen Mermelstein		Clerical		8,930	10	25.00	Salary	2,830	21	2
3	Jacob Mermelstein		Clerical		353,698	10	25.00	Salary	112,088	21	3
4	Joel Mermelstein		Clerical		354,462	10	25.00	Salary	112,329	21	4
5	Jeffrey Mermelstein		Clerical		460,772	10	25.00	Salary	146,019	21	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 389,582		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: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Payroll	Resident Beds	748	4	$ 1,597,872	$ 1,597,872	180	$ 384,515	1
2	27	Payroll Taxes	Resident Beds	748	4	177,295		180	42,665	2
3	33	Real Estate Tax	Resident Beds	748	4	51,185		180	12,317	3
4	5	Utilities	Resident Beds	748	4	14,844		180	3,572	4
5	6	Repairs & Maintenance	Resident Beds	748	4	13,043		180	3,139	5
6	26	Insurance	Resident Beds	748	4	12,677		180	3,051	6
7	19	Professional Fees	Resident Beds	748	4	60,541		180	14,569	7
8	21	Office	Resident Beds	748	4	123,350		180	29,683	8
9	17	Marvin Mermelstein	Resident Beds	748	4	67,802	67,802	180	16,316	9
10	21	Doreen Mermelstein	Resident Beds	748	4	11,760	11,760	180	2,830	10
11	21	Jacob Mermelstein	Resident Beds	748	4	465,786	230,442	180	112,088	11
12	21	Joel Mermelstein	Resident Beds	748	4	466,791	231,447	180	112,329	12
13	21	Jeffrey Mermelstein	Resident Beds	748	4	606,791	371,447	180	146,019	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					$ 3,669,737	$ 2,510,770		$ 883,093	25

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	291,406	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.)	$	285,356	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,050)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)	$	278,500	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.)**	$	3,834	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.	$	276,284	7

Assessed Value from Real Estate Tax Bill:	2024	1,355,000	8
Real Estate Tax Bill for Calendar Year:	2020	264,293	9
	2021	271,473	10
	2022	277,671	11
	2023	285,692	12
	2024	273,039	13

Line 4: 273039 x 1.02

FOR BHF USE ONLY

14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 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 Rob Strukoff

TELEPHONE 847-715-2522 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-06-106-001-0000		$ 273,039.24	$ 273,039.24
2.			$	$
3.			$	$
4.			$	$
5.	Allocated from Mgmt Co		$	$
6.	10-35-325-015-0000		$ 43,099.76	$ 10,372.00
7.	10-35-325-029-0000		$ 8,084.94	$ 1,945.00
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 324,223.94	$ 285,356.24

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Numb Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,192 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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

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

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (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. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

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

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	180		1989		$ 1,536,832	$	31.5	$	$	$ 1,536,832	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System			1990	9,200		27.5			9,200	9
10	Interior Improvements			1990	32,039		27.5			32,039	10
11	Elevator			1990	5,300		27.5			5,300	11
12	Tiling & Lobby Office			1990	10,143		27.5			10,143	12
13	Building Improvements			1991	3,230		27.5			3,230	13
14	Building Improvements			1991	4,806		27.5			4,806	14
15	Tiles			1991	11,906		27.5			11,906	15
16	Radiator Cover			1992	12,400		27.5			12,400	16
17	Electrical Work			1992	3,500		27.5			3,500	17
18	Building Improvements			1993	21,476		27.5			21,476	18
19	Building Improvements			1995	34,754		27.5			34,754	19
20	Flooring & Tile			1996	5,355		27.5			5,355	20
21	Generator			1996	35,589		27.5			35,589	21
22	Alarm System			1996	3,744		27.5			3,744	22
23	Roof			1996	1,200		27.5			1,200	23
24	Smoke Eater			1993	4,600		10			4,600	24
25	A/C			1993	2,550		10			2,550	25
26	Carpet			1993	3,527		10			3,527	26
27	Boiler			1993	3,600		10			3,600	27
28	A/C			1994	5,122		10			5,122	28
29	Hot Water Heater			1995	4,160		10			4,160	29
30	A/C			1995	2,816		10			2,816	30
31	Glass			1995	647		10			647	31
32	Roof			1997	21,350		27.5			21,350	32
33	Phone System			1997	13,666		27.5			13,666	33
34	Electrical Work			1997	49,685		27.5			49,685	34
35	Central A/C			1997	35,499		27.5			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: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Office Construction	1997	$ 4,442	$	27.5	$	$	$ 4,442	37
38	Fire Alarm & Sprinkler	1997	2,475		27.5			2,475	38
39	Doors & Construction	1997	8,190		27.5	298	298	7,831	39
40	Plumbing-Toilets & Pipes	1997	4,719		27.5			4,719	40
41	Roof	1998	3,900		27.5			3,900	41
42	HVAC	1998	2,700		27.5			2,700	42
43	Door & Construction	1998	2,729		27.5			2,729	43
44	Phone System	1998	1,283		27.5			1,283	44
45	Door	1999	2,500		27.5			2,500	45
46	Fire Damper	1999	1,783		27.5			1,783	46
47	Water System	1999	6,000		27.5			6,000	47
48	Door Construction	1999	2,500		27.5			2,500	48
49	Kitchen & Tiling	1999	10,250		27.5			10,250	49
50	New Windows	2001	1,300		27.5			1,300	50
51	Doors & Frames	2001	2,025		27.5			2,025	51
52	Electric Wiring	2001	443		27.5			443	52
53	Wall Repair	2001	1,000		27.5			1,000	53
54	Roof Repair	2003	1,150		27.5			1,150	54
55	Brick Paver	2004	40,000		27.5	1,450	1,450	38,620	55
56	Tuckpointing	2004	23,518		27.5	853	853	23,046	56
57	Bldg Imp	1995	74,705		27.5			74,705	57
58	Bathroom Remodeling	2005	5,125		27.5	187	187	4,685	58
59	Boilerb Insulation	2006	32,500		27.5	1,179	1,179	27,624	59
60	Symmetry Construction	2006	5,500		27.5	201	201	4,710	60
61	Kitchen Fire Safety System	2006	1,600		27.5	58	58	1,354	61
62	Wireless Temp Control	2006	3,500		27.5	127	127	3,458	62
63	Lock	2006	380		27.5	14	14	368	63
64	Roof	2006	7,100		27.5	259	259	5,976	64
65	Boiler Insulation	2007	26,890		27.5	981	981	22,247	65
66	Power Flame Gas Burner	2007	7,000		27.5	255	255	5,537	66
67	Fire Alarm & Sprinkler	2012	4,300		27.5	157	157	2,191	67
68	Doors Project	2012	3,978		27.5	144	144	2,020	68
69	Elevator Improvements	2012	9,000		27.5	327	327	4,575	69
70	TOTAL (lines 4 thru 69)		$ 2,183,181	$		$ 6,490	$ 6,490	$ 2,158,842	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: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,183,181	$		$ 6,490	$ 6,490	$ 2,158,842	1
2	Water Heater	2013	5,100		27.5	186	186	2,229	2
3	Relocate Panelboard & Circuits	2014	9,500		27.5	345	345	4,142	3
4	A/c	2014	7,650		27.5	279	279	3,343	4
5	Pipes & Wires	2014	4,800		27.5	174	174	2,093	5
6	Wiring Upgrade	2014	7,880		27.5	286	286	3,387	6
7	Sprinkler System	2015	3,994		27.5	145	145	1,598	7
8	Elevator	2015	104,660		27.5	4,160	4,160	42,441	8
9	Water Heater	2015	8,369		27.5	305	305	3,326	9
10	Fire Service	2015	22,000		27.5	799	799	8,060	10
11	Elevator Motor & Break assembly	2016	19,837		27.5	723	723	7,164	11
12	Refrigerator Cooler Components	2016	8,500		27.5	309	309	2,961	12
13	A/C Unit	2016	20,938		27.5	760	760	7,287	13
14	Elevator Valve	2016	3,800		27.5	138	138	1,311	14
15	Circuit Breaker Load	2018	3,800		27.5	138	138	1,035	15
16	Backflow	2019	4,955		15	381	381	2,667	16
17	Roof	2019	9,000		15	693	693	4,847	17
18	Access Point Installation Surveilance	2022	6,424		15	428	428	1,712	18
19	Remove Old Chimney Cap & Rebuild Chimney	2022	5,000		15	333	333	1,332	19
20	Elevator-Furnish & Install New Tank Unit	2022	15,800		15	1,053	1,053	4,212	20
21	Plumbing Repair by Ezra	2025	11,600		15	773	773	773	21
22	Telecom 24/7	2025	7,290		15	486	486	486	22
23	Platinum Security	2025	23,200		15	1,547	1,547	1,547	23
24	Harrison Mechanical	2025	3,480		15	232	232	232	24
25									25
26									26
27									27
28	Financial Statement Depreciation			68,483			(68,483)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,500,758	$ 68,483		$ 21,163	$ (47,320)	$ 2,267,027	34

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

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	$ 61,824	$	$ 8,832	$ 8,832	7	$ 39,514	71
72	Current Year Purchases	5,075		508	508	10	508	72
73	Fully Depreciated Assets	586,054					586,054	73
74								74
75	TOTALS	$ 652,953	$	$ 9,340	$ 9,340		$ 626,076	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,258,711	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,483	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,503	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (37,980)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,893,103	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2026	$
13.	/2027	$
14.	/2028	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2025 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,454,243	$ 1,454,243	1
2	Cash-Patient Deposits	241,390	241,390	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,049,414	1,049,414	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,089	46,089	6
7	Other Prepaid Expenses	9,228	9,228	7
8	Accounts Receivable (owners or related parties)	28,586	28,586	8
9	Other(specify): Investments		401,846	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,828,950	$ 3,230,796	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	932,286	1,006,991	15
16	Equipment, at Historical Cost	633,000	633,000	16
17	Accumulated Depreciation (book methods)	(1,313,103)	(2,925,143)	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)**	$ 252,183	$ 356,680	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,081,133	$ 3,587,476	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,243,211	$ 1,243,211	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	318,819	318,819	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	167,037	167,037	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,976	9,976	31
32	Accrued Real Estate Taxes(Sch.IX-B)		278,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Acc Mgmt Fees & Rent	6,047,727	6,047,727	36
37	Patient Credit Balances	518,012	518,012	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,304,782	$ 8,583,282	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)**	$ 8,304,782	$ 8,583,282	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,223,649)	$ (4,995,806)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,081,133	$ 3,587,476	48

*(See instructions.)

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,051,796)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (6,051,796)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	828,147	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 828,147	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)**	$ (5,223,649)	24 *

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

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,445,734	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,445,734	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	296,242	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)**	$ 296,242	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	61,680	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 61,680	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,803,656	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,440,002	31
32	Health Care	2,800,185	32
33	General Administration	2,372,465	33
	B. Capital Expense		
34	Ownership	589,610	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	773,247	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,975,509	40
41	**Income before Income Taxes (line 30 minus line 40)****	828,147	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 828,147	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 634,731.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,090,536.00	45
46	MMAI-Medicaid is the Primary Payer	537,402.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	183,065.00	48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,445,734	56

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,320	$ 109,463	$ 47.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,015	8,560	354,163	41.37	3
4	Licensed Practical Nurses	5,012	5,413	208,277	38.48	4
5	CNAs & Orderlies	36,535	40,219	1,000,072	24.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,920	2,110	45,140	21.39	9
10	Activity Assistants	4,749	5,388	109,993	20.41	10
11	Social Service Workers	5,778	6,063	151,577	25.00	11
12	Dietician					12
13	Food Service Supervisor	2,131	2,371	63,419	26.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,588	20,103	401,574	19.98	15
16	Dishwashers					16
17	Maintenance Workers	2,216	2,391	62,489	26.14	17
18	Housekeepers	14,670	16,494	337,559	20.47	18
19	Laundry	2,093	2,267	45,000	19.85	19
20	Administrator	4,160	4,346	209,818	48.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,777	5,404	109,038	20.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,248	2,352	40,316	17.14	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	1,935	3,133	93,620	29.88	33
34	TOTAL (lines 1 - 33)	117,907	128,934	$ 3,341,518 *	$ 25.92	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,122	1-3	35
36	Medical Director	Monthly	2,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	14,991	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,613		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,458	$ 267,460	10-3	50
51	Licensed Practical Nurses	4,212	231,684	10-3	51
52	Certified Nurse Assistants/Aides	2,816	98,577	10-3	52
53	TOTAL (lines 50 - 52)	11,486	$ 597,721		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Aharon Marizan	Administrator	0	$ 209,818
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 209,818

B. Administrative - Other

Description	Amount
Nivram Mgmt-Mgmt Fees	$ 1,109,065
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,109,065
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider CPA	Accounting	$ 14,000
Gary Weintraub	Legal	2,045
Fred Berkovitz	Legal	2,149
GARNET	MDS Cons	24,075
ZEZ Group	Website Cons	8,378
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 50,647

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,626
Unemployment Compensation Insurance	17,028
FICA Taxes	251,613
Employee Health Insurance	99,693
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 397,960

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	6,776
(Indicate # of checks performed)	
Patient Background Checks	1,733
Association Dues (total from pg 22, #4)	
Apploi	3,600
Various	3,452
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,551

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winston Manor Cnv Nursing # 0035782 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XX. GENERAL INFORMATION:

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

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
Total	

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

Total	

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

Total	

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ **4,000** Line **10**

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **773,247**
This amount is to be recorded on line 42 of Schedule V.

(8) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(9) 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**

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Indicate the amount. $

(12) 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? If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients?

d. Have vehicle usage logs been maintained?

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(15) 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.