

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0039966 Facility Name: Balmoral Home Inc. d/b/a/ Balmoral Nursing Home Address: 2055 West Balmoral Chicago 60625 County: Cook Telephone Number: (773) 561-8661 Fax #: (773) 561-9376 HFS ID Number: Date of Initial License for Current Owners: 09/10/1993 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code 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 1/1/11 to 12/31/11 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 Principal (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 Balmoral Home Inc. d/b/a/ Balmoral Nursing Home

0039966 Report Period Beginning: 1/1/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>213</u>	Skilled (SNF)	<u>213</u>	<u>77,745</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>213</u>	TOTALS	<u>213</u>	<u>77,745</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	<u>66,892</u>	<u>846</u>	<u>5,428</u>	<u>73,166</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>66,892</u>	<u>846</u>	<u>5,428</u>	<u>73,166</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.11%

D. How many bed-hold days during this year were paid by the Department? 919 (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)
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 ☐

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 10/10/1993

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1993 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 34 and days of care provided 5,235

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

Balmoral Home Inc. d/b/a/ Balmoral Nursing

0039966

Report Period Beginning:

1/1/11

Ending:

12/31/11

Page 3

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	253,487	26,553	9,925	289,965		289,965	25,000	314,965			1
2	Food Purchase		330,990		330,990	(44,744)	286,246	(541)	285,705			2
3	Housekeeping	152,709	35,373		188,082		188,082		188,082			3
4	Laundry	91,536	11,113		102,649		102,649		102,649			4
5	Heat and Other Utilities			153,312	153,312		153,312	4,342	157,654			5
6	Maintenance		47,361	71,924	119,285		119,285	166,825	286,110			6
7	Other (specify):* Attached Schedule			19,219	19,219		19,219	164	19,383			7
8	TOTAL General Services	497,732	451,390	254,380	1,203,502	(44,744)	1,158,758	195,790	1,354,548			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,498,133	288,120	121,462	1,907,715		1,907,715		1,907,715			10
10a	Therapy											10a
11	Activities		2,840		2,840		2,840		2,840			11
12	Social Services			5,343	5,343		5,343		5,343			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,498,133	290,960	126,805	1,915,898		1,915,898		1,915,898			16
	C. General Administration											
17	Administrative			941,468	941,468		941,468	(417,848)	523,620			17
18	Directors Fees											18
19	Professional Services			101,868	101,868		101,868	(961)	100,907			19
20	Dues, Fees, Subscriptions & Promotions			24,763	24,763		24,763	(15,133)	9,630			20
21	Clerical & General Office Expenses	636,411		37,136	673,547		673,547	136,764	810,311			21
22	Employee Benefits & Payroll Taxes			479,823	479,823	44,744	524,567	63,355	587,922			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,225	2,225		2,225		2,225			24
25	Other Admin. Staff Transportation			3,311	3,311		3,311	(135)	3,176			25
26	Insurance-Prop.Liab.Malpractice			117,991	117,991		117,991	1,771	119,762			26
27	Other (specify):*											27
28	TOTAL General Administration	636,411		1,708,585	2,344,996	44,744	2,389,740	(232,187)	2,157,553			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,632,276	742,350	2,089,770	5,464,396		5,464,396	(36,397)	5,427,999			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			10,047	10,047		10,047	863	10,910			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			744	744		744		744			32
33	Real Estate Taxes							284,645	284,645			33
34	Rent-Facility & Grounds			1,839,545	1,839,545		1,839,545	(1,839,545)				34
35	Rent-Equipment & Vehicles			11,041	11,041		11,041	601	11,642			35
36	Other (specify):*											36
37	TOTAL Ownership			1,861,377	1,861,377		1,861,377	(1,553,436)	307,941			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		384,282	8,420	392,702		392,702		392,702			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,618	116,618		116,618		116,618			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		384,282	125,038	509,320		509,320		509,320			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,632,276	1,126,632	4,076,185	7,835,093		7,835,093	(1,589,833)	6,245,260			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	128	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	(541)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(561)	25		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16)	21		18
19	Entertainment				19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance	(750)	22		21
22	Special Legal Fees & Legal Retainers	(2,755)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,515)	21		24
25	Fund Raising, Advertising and Promotional	(16,283)	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	(540)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (34,933)		\$	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)			34
35	Other- Attach Schedule	(1,554,900)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,554,900)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,589,833)		37

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

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

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

Report Period Beginning:

Ending:

ID#

0039966

1/1/11

12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Trust Fee	\$ (75)	21	1
2	Franchise Tax	(100)	21	2
3	Sales Taxes - Management Company	(365)	2	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
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26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(540)		49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00	Winston Manor Nursing Home	Chicago	Nivram Mngmt, Inc.	Lincolnwood	Management
Joseph Mermelstein Trust	50.00	Chicago Ridge Nursing & Rehab Center	Chicago Ridge			

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	25	Auto Expense	\$	Nivram Management Inc.	50.00%	\$ 355	\$ 355	1
2	V	20	Advertising		Nivram Management Inc.	50.00%	725	725	2
3	V	21	Bank Charges		Nivram Management Inc.	50.00%	200	200	3
4	V	21	Delivery Expense		Nivram Management Inc.	50.00%	537	537	4
5	V	21	Office Expense		Nivram Management Inc.	50.00%	2,963	2,963	5
6	V	20	Dues & Subscriptions		Nivram Management Inc.	50.00%	283	283	6
7	V	22	Payroll Taxes		Nivram Management Inc.	50.00%	44,188	44,188	7
8	V	5	Utilities		Nivram Management Inc.	50.00%	4,342	4,342	8
9	V	26	Insurance		Nivram Management Inc.	50.00%	1,771	1,771	9
10	V	22	Health Insurance		Nivram Management Inc.	50.00%	19,917	19,917	10
11	V	7	Scavenger		Nivram Management Inc.	50.00%	164	164	11
12	V	35	Rental Equipment		Nivram Management Inc.	50.00%	601	601	12
13	V	2	Sales Taxes		Nivram Management Inc.	50.00%	365	365	13
14	Total			\$			\$ 76,411	\$ * 76,411	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	21	Postaage	\$	Nivram Management Inc.	50.00%	\$ 321	\$	321
16	V	19	Legal & Accounting		Nivram Management Inc.	50.00%	1,794		1,794
17	V	20	Licenses & Permits		Nivram Management Inc.	50.00%	142		142
18	V	25	Travel		Nivram Management Inc.	50.00%	71		71
19	V	30	Depreciation		Nivram Management Inc.	50.00%	735		735
20	V	21	Data Processing		Nivram Management Inc.	50.00%	532		532
21	V	21	Telephone		Nivram Management Inc.	50.00%	2,684		2,684
22	V	6	Repairs & Maintenance		Nivram Management Inc.	50.00%	1,315		1,315
23	V	6	Plant Supervisor Salary		Nivram Management Inc.	50.00%	165,510		165,510
24	V	17	Asst. Administrator Salary		Nivram Management Inc.	50.00%	315,006		315,006
25	V	21	Office Manager Salary		Nivram Management Inc.	50.00%	38,187		38,187
26	V	1	Food Service Supervisor Salary		Nivram Management Inc.	50.00%	25,000		25,000
27	V	17	Administrative Salaries		Nivram Management Inc.	50.00%	50,601		50,601
28	V	17	Administrator Salary		Nivram Management Inc.	50.00%	158,013		158,013
29	V	21	Clerical Salaries		Nivram Management Inc.	50.00%	105,146		105,146
30	V	17	Management Fees	941,468	Nivram Management Inc.	50.00%			(941,468)
31	V	33	Real Estate Taxes				284,645		284,645
32	V	34	Rental Income	1,839,545					(1,839,545)
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 2,781,013			\$ 1,149,702	\$ *	(1,631,311)

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Balmoral Home Inc. d/b/a/ Balmoral Nursing # 0039966 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	Administrative Asst.	Administrative	0.00	50,000	13	33.33	Salary	\$ 25,000	17-7	1
2	Louise Mermelstein	Food Sev Supervr	Support	0.00	50,000	6	33.33	Salary	25,000	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	319,364	6	34.13	Salary	165,510	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	76,373	13	33.33	Salary	38,187	21-7	4
5											5
6	Marvin Mermelstein	Administrative Asst.	Administrative	See Above	479,047	9	34.13	Salary	248,265	17-7	6
7	Joseph Mermelstein	Owner	Administrative	50.00	49,399	4	34.13	Salary	25,601	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 527,563		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 Balmoral Home Inc. d/b/a/ Balmoral Nursing Home # 0039966 Report Period Beginning: 1/1/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	25	Auto Expense	Resident Beds	624	3	\$ 1,041	\$	213	\$ 355	1
2	20	Advertising	Resident Beds	624	3	2,123		213	725	2
3	21	Bank Charges	Resident Beds	624	3	585		213	200	3
4	21	Delivery Expense	Resident Beds	624	3	1,572		213	537	4
5	21	Office Expense	Resident Beds	624	3	8,680		213	2,963	5
6	20	Dues & Subscriptions	Resident Beds	624	3	829		213	283	6
7	22	Payroll Taxes	Resident Beds	624	3	129,453		213	44,188	7
8	5	Utilities	Resident Beds	624	3	12,724		213	4,342	8
9	26	Insurance	Resident Beds	624	3	5,189		213	1,771	9
10	22	Health Insurance	Resident Beds	624	3	58,350		213	19,917	10
11	7	Scavenger	Resident Beds	624	3	480		213	164	11
12	35	Rental Equipment	Resident Beds	624	3	1,760		213	601	12
13	2	Sales Taxes	Resident Beds	624	3	1,070		213	365	13
14	21	Postaage	Resident Beds	624	3	941		213	321	14
15	19	Legal & Accounting	Resident Beds	624	3	5,255		213	1,794	15
16	20	Licenses & Permits	Resident Beds	624	3	415		213	142	16
17	25	Travel	Resident Beds	624	3	209		213	71	17
18	30	Depreciation	Resident Beds	624	3	2,153		213	735	18
19	21	Data Processing	Resident Beds	624	3	1,558		213	532	19
20	21	Telephone	Resident Beds	624	3	7,863		213	2,684	20
21	6	Repairs & Maintenance	Resident Beds	624	3	3,852		213	1,315	21
22	6	Plant Supervisor Salary	Direct Cost	1	1	165,510		1	165,510	22
23	17	Asst. Administrator Salary	Direct Cost	1	1	315,006		1	315,006	23
24	21	Office Manager Salary	Direct Cost	1	1	38,187		1	38,187	24
25	TOTALS					\$ 764,805	\$		\$ 602,708	25

Facility Name & ID Number Balmoral Home Inc. d/b/a/ Balmoral Nursing Home # 0039966 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 Line Reference	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	
1	1	Food Serv Supervisor Salary	Direct Cost	1	1	\$ 25,000	\$	1	\$ 25,000	1
2	17	Administrative Salaries	Direct Cost	1	1	50,601		1	50,601	2
3	17	Administrator Salary	Direct Cost	1	1	158,013		1	158,013	3
4	21	Clerical Salaries	Direct Cost	1	1	105,146		1	105,146	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	TOTALS					\$ 338,760	\$		\$ 338,760	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Parkway Bank & Trust		X	Line of Credit	Int Only	12/20/11	230,765		12/28/12	0.0325	180	6	
7	Medicare		X	Medicare Coinsurance Bad Debt Prepayments							564	7	
8												8	
9	TOTAL Facility Related						\$ 230,765	\$			\$ 744	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 230,765	\$			\$ 744	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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	250,000	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.)				\$	284,645	2
3. Under or (over) accrual (line 2 minus line 1).				\$	34,645	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	250,000	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.				\$	284,645	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	238,200	8		
		2007	235,657	9		
		2008	238,021	10		
		2009	272,770	11		
		2010	284,645	12		
				FOR BHF USE ONLY		
				13	FROM R. E. TAX STATEMENT FOR 2010 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Balmoral Home Inc. d/b/a/ Balmoral Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039966

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

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

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

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>14-07-109-036-0000</u>	<u>Nursing Home</u>	\$ <u>284,645.00</u>	\$ <u>284,645.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>284,645.00</u>	\$ <u>284,645.00</u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,360

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

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

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

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

1. Total Amount Incurred: _____

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

3. Current Period Amortization: _____

4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>33,375</u>	<u>1993</u>	<u>\$ 90,430</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	33,375		\$ 90,430	3

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	213		1993	1968	\$ 985,048	\$		\$	\$	985,048
5										
6										
7										
8										
	Improvement Type**									
9	Leasehold Improvements			1994	8,500	218	39	218		3,933
10	Fence			1994	2,700	69	39	69		1,178
11	Leasehold Improvements			1995	4,813	124	39	124		1,999
12	Leasehold Improvements			1996	3,750		10			3,750
13	Fire Alarm			1996	8,750	224	39	224		3,578
14	Laundry Chute			1996	2,181	56	39	56		889
15	Concrete Ramp			1996	2,500	64	39	64		990
16	Phone System			1993	4,475		5			4,475
17	Time Clock System			1993	1,853		7			1,853
18	Carpet			1993	1,144		7			1,144
19	Phone System			1994	2,967		7			2,967
20	Hot Water System			1995	3,035		7			3,035
21	Awning and Sign			1996	5,923	152	39	152		2,285
22	Parking Lot			1997	6,600	271	20	330	59	5,280
23	Remodeling Laundry Area			1997	5,400	139	39	139		2,059
24	Remodeling Laundry Area			1997	19,779	507	39	507		7,501
25	Handrails			1997	5,750	148	39	147	(1)	2,141
26	Fire Alarm			1997	16,726	429	39	429		6,269
27	Light Fixtures			1997	6,552	39	39	38	(1)	5,612
28	Boiler			1997	925	24	39	24		343
29	Kitchen Improvements			1997	2,875	74	39	74		1,061
30	Elevator			1997	2,300	59	39	59		838
31	Bathroom Remodeling			1997	312	8	39	8		113
32	HVAC, Boiler			1998	14,915	382	39	382		5,176
33	Ward Doors			1998	2,803	72	39	72		956
34	Concrete Steps			1998	2,500	64	39	64		867
35	Fire Alarm			1998	16,000	410	39	410		5,178
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

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Boiler and Duckwork	1999	\$ 18,500	\$ 475	39	\$ 474	\$ (1)	\$ 6,145	37
38	Windows	1999	1,498	38	39	39	1	492	38
39	Cooling Tower	2000	8,860	228	39	227	(1)	2,659	39
40	Heater	2000	3,000	77	39	77		862	40
41	Vestibule Remodeling	2001	4,200	108	39	108		1,191	41
42	Elevator	2002	1,500	39	39	39		381	42
43	Carpet	2002	1,500	39	39	39		381	43
44	A/C Unit	2003	24,800		5			24,800	44
45	Elevator Hydraulic Power Unit	2006	14,000	359	39	359		1,825	45
46	Water Heater	2006	3,900	100	39	100		500	46
47	Wet Che Suppression System	2006	2,225	57	39	57		285	47
48	Cooling Tower Slinger Assemble	2006	2,400	62	39	62		350	48
49	Motor Starter on Cooling Tower	2006	1,117	29	39	28	(1)	151	49
50	Pump Motor on Hot Water Heater	2006	1,406	36	39	36		213	50
51	Kitchen Exhaust Fan	2007	4,848	125	39	124	(1)	569	51
52	80 Ton Cooling Tower	2007	85,500	2,193	39	2,192	(1)	9,134	52
53	New Brick for Chimney	2007	5,500	141	39	141		588	53
54	Concret Stairs	2007	6,500	167	39	166	(1)	679	54
55	Sump Pump	2007	3,600	90	39	90		424	55
56	Water Heater	2008	5,200	133	39	133		410	56
57	Valves	2010	4,500	115	39	115		202	57
58	Sprinkler System Heads & Valves	2011	3,330	14	39	14	0	14	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,348,960	\$ 8,158		\$ 8,210	\$ 52	\$ 1,112,773	70

**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	\$25,666	\$1,889	\$1,858	\$(31)	5-7	\$25,666	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	198,256					198,256	73
74	Management Co.		735	842	107			74
75	TOTALS	\$223,922	\$2,624	\$2,700	\$76		\$223,922	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	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)		\$1,663,312	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$10,782	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$10,910	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$128	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$1,336,695	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
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: _____*

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 3,403 Description: Copier \$1824; Icemaker \$978; Copier - Management Co. \$601
(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	Administrative	2008 Nissan Armada	\$ 570.00	\$ 5,969	17
18	Administrative	2012 Subaru Outback	509.00	2,270	18
19					19
20					20
21	TOTAL		\$ 1,079.00	\$ 8,239	21

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			383,502			383,502	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): Attached Schedule					780	8,420		9,200	13
14	TOTAL			\$		\$ 384,282	\$ 8,420		\$ 392,702	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	\$ 306,363	\$ 306,363	1
2	Cash-Patient Deposits	119,438	119,438	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,914,190	1,914,190	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,051	76,051	6
7	Other Prepaid Expenses	35,884	35,884	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,451,926	\$ 2,451,926	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		90,430	13
14	Buildings, at Historical Cost		985,048	14
15	Leasehold Improvements, at Historical Cost	316,836	316,836	15
16	Equipment, at Historical Cost	270,997	270,997	16
17	Accumulated Depreciation (book methods)	(348,536)	(1,333,584)	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)	\$ 239,297	\$ 329,727	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,691,223	\$ 2,781,653	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 171,551	\$ 171,551	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	119,443	119,443	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,767	102,767	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	250,000	250,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Attached Schedule</u>	1,669,646	1,669,646	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,313,407	\$ 2,313,407	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)	\$ 2,313,407	\$ 2,313,407	46
47	TOTAL EQUITY(page 18, line 24)	\$ 377,816	\$ 468,246	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,691,223	\$ 2,781,653	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,053,681)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,053,681)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,218,637	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	6,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(793,140)	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)	\$ 1,431,497	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)	\$ 377,816	24 *

* This must agree with page 17, line 47.

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,675,448	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,675,448	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	16,498	6
7	Oxygen	22,808	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 39,306	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,553	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,553	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Attached Schedule</u>	332,500	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 332,500	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,053,807	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,203,502	31
32	Health Care	1,915,898	32
33	General Administration	2,344,996	33
	B. Capital Expense		
34	Ownership	1,861,377	34
	C. Ancillary Expense		
35	Special Cost Centers	392,701	35
36	Provider Participation Fee	116,618	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,835,092	40
41	Income before Income Taxes (line 30 minus line 40)**	2,218,715	41
42	Income Taxes	(78)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,218,637	43

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

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

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

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

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	2,080	2,080	\$ 93,960	\$ 45.17	1
2	Assistant Director of Nursing	1,901	2,109	72,824	34.53	2
3	Registered Nurses	22,660	24,005	661,531	27.56	3
4	Licensed Practical Nurses	3,817	4,065	89,615	22.05	4
5	CNAs & Orderlies	73,773	77,099	746,987	9.69	5
6	CNA Trainees					6
7	Licensed Therapist	4,097	4,400	63,372	14.40	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,023	2,239	37,693	16.83	9
10	Activity Assistants	3,657	4,005	63,049	15.74	10
11	Social Service Workers	10,561	11,197	159,420	14.24	11
12	Dietician					12
13	Food Service Supervisor	2,063	2,239	45,197	20.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,338	24,489	253,487	10.35	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	14,228	15,580	152,709	9.80	18
19	Laundry	7,981	8,701	91,536	10.52	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,126	4,382	59,542	13.59	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	3,898	4,122	41,354	10.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,203	190,712	\$ 2,632,276 *	\$ 13.80	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	\$ 9,925	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	2,864	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	5,343	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,132		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,569	\$ 118,598	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,569	\$ 118,598		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberBalmoral Home Inc. d/b/a/ Balmoral Nursing Home# 0039966Report Period Beginning: 1/1/11Ending: 12/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$

B. Administrative - Other

Description

Amount

Management Fees

\$ 941,468

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 941,468

C. Professional Services

Vendor/Payee

Type

Amount

Attached Schedule

\$ 101,868

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 101,868

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 50,815

Unemployment Compensation Insurance

31,468

FICA Taxes

196,665

Employee Health Insurance

167,102

Employee Meals

54,294

Illinois Municipal Retirement Fund (IMRF)*

Chicago Head Tax

3,968

Union Pension

29,055

Allocation from Management Company

64,105

Employee Benefit

750

Less Owner or Key-Man Insurance

(750)

TOTAL (agree to Schedule V, line 22, col.8)

\$ 597,472

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

\$ 2,200

Advertising: Employee Recruitment

254

Health Care Worker Background Check

(Indicate # of checks performed 1)

10

Patient Background Checks

96

Advertising and Promotion

15,558

Allocation from Management Company

1,150

Attached Schedule

5,781

Less: Public Relations Expense

()

Non-allowable advertising

(16,283)

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 9,630

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

2,225

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 2,225

* Attach copy of IMRF notifications

**See instructions.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 44,744 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? N/A

d. Have vehicle usage logs been maintained? No

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No

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

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

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