

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

Address: 2055 West Balmoral Avenue Chicago 60625
Number City Zip Code

County: Cook

Telephone Number: (773) 561-8661 Fax # (773) 561-9376

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Sanford B. Alper Telephone Number: (847) 580-4100
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 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) _____ (Date) _____
(Print Name and Title) Sanford B. Alper Principal
(Firm Name & Address) Kessler, Orean, 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

Facility Name & ID Number Balmoral Home

0039966 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>213</u>					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>213</u>	Skilled (SNF)	<u>213</u>	<u>77,958</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>77,958</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>67,862</u>	<u>456</u>	<u>5,645</u>	<u>73,963</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>67,862</u>	<u>456</u>	<u>5,645</u>	<u>73,963</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.88%

D. How many bed-hold days during this year were paid by the Department?
1,160 (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 5,110

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	309,947	29,351	9,716	349,014		349,014	25,000	374,014			1
2	Food Purchase		355,957		355,957	(37,248)	318,709	(824)	317,885			2
3	Housekeeping	156,340	45,877		202,217		202,217		202,217			3
4	Laundry	91,123	8,489		99,612		99,612		99,612			4
5	Heat and Other Utilities			149,577	149,577		149,577	6,020	155,597			5
6	Maintenance		134,243		134,243		134,243	79,755	213,998			6
7	Other (specify):* Attached Schedule			14,880	14,880		14,880	164	15,044			7
8	TOTAL General Services	557,410	573,917	174,173	1,305,500	(37,248)	1,268,252	110,115	1,378,367			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,760,660	229,901	78,484	2,069,045		2,069,045		2,069,045			10
10a	Therapy	63,650			63,650		63,650		63,650			10a
11	Activities	116,752	1,826		118,578		118,578		118,578			11
12	Social Services	167,958		4,571	172,529		172,529		172,529			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,109,020	231,727	83,055	2,423,802		2,423,802		2,423,802			16
	C. General Administration											
17	Administrative			1,045,670	1,045,670		1,045,670	(346,780)	698,890			17
18	Directors Fees											18
19	Professional Services			95,213	95,213		95,213	2,833	98,046			19
20	Dues, Fees, Subscriptions & Promotions			15,162	15,162		15,162	(8,126)	7,036			20
21	Clerical & General Office Expenses	53,194		35,781	88,975		88,975	120,329	209,304			21
22	Employee Benefits & Payroll Taxes			486,743	486,743	37,248	523,991	49,287	573,278			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,495	3,495		3,495		3,495			24
25	Other Admin. Staff Transportation			4,389	4,389		4,389	(533)	3,856			25
26	Insurance-Prop.Liab.Malpractice			122,403	122,403		122,403	1,201	123,604			26
27	Other (specify):*											27
28	TOTAL General Administration	53,194		1,808,856	1,862,050	37,248	1,899,298	(181,789)	1,717,509			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,719,624	805,644	2,066,084	5,591,352		5,591,352	(71,674)	5,519,678			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			9,959	9,959		9,959	8,627	18,586			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,299	1,299		1,299	(1,299)				32
33	Real Estate Taxes							238,082	238,082			33
34	Rent-Facility & Grounds			1,864,921	1,864,921		1,864,921	(1,864,921)				34
35	Rent-Equipment & Vehicles			8,930	8,930		8,930	853	9,783			35
36	Other (specify):*											36
37	TOTAL Ownership			1,885,109	1,885,109		1,885,109	(1,618,658)	266,451			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,916	326,805	336,721		336,721		336,721			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			847,233	847,233		847,233		847,233			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		9,916	1,174,038	1,183,954		1,183,954		1,183,954			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,719,624	815,560	5,125,231	8,660,415		8,660,415	(1,690,332)	6,970,083			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	(895)	30		9
10	Interest and Other Investment Income	(1,305)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(824)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(1,946)	25		15
16	Personal Expenses (Including Transportation)	(680)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,100)	21		18
19	Entertainment	(12,607)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance	(750)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,955)	21		24
25	Fund Raising, Advertising and Promotional	(9,630)	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	(578)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (43,270)		\$	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	(1,647,062)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,647,062)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,690,332)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Trust Fee	\$	21	1
2	Frachise Tax	(75)	21	2
3	Sales Taxes - Management Company	(100)	2	3
4	Contributions - Management Company	(306)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
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12				12
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(578)		49

Summary A

12/31/2012

[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%	\$ 147	\$ 147	1
2	V	20	Advertising		Nivram Management, Inc.	50.00%	292	292	2
3	V	21	Bank Charges		Nivram Management, Inc.	50.00%	32	32	3
4	V	6	Repairs and Maintenance		Nivram Management, Inc.	50.00%	2,610	2,610	4
5	V	5	Utilities		Nivram Management, Inc.	50.00%	6,020	6,020	5
6	V	21	Delivery Expense		Nivram Management, Inc.	50.00%	212	212	6
7	V	21	Donations		Nivram Management, Inc.	50.00%	97	97	7
8	V	21	Office Expense		Nivram Management, Inc.	50.00%	3,717	3,717	8
9	V	20	Dues & Subscriptions		Nivram Management, Inc.	50.00%	1,096	1,096	9
10	V	21	Taxes Other		Nivram Management, Inc.	50.00%	101	101	10
11	V	32	Interest Expense		Nivram Management, Inc.	50.00%	6	6	11
12	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	45,626	45,626	12
13	V	26	Insurance Expense		Nivram Management, Inc.	50.00%	1,201	1,201	13
14	Total			\$			\$ 61,157	\$ * 61,157	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	22	Health Insurance	\$	Nivram Management, Inc.	50.00%	\$ 16,268	\$ 16,268	15
16	V	7	Scavenger		Nivram Management, Inc.	50.00%	164	164	16
17	V	35	Rental Equipment		Nivram Management, Inc.	50.00%	853	853	17
18	V	2	Sales Taxes		Nivram Management, Inc.	50.00%	306	306	18
19	V	21	Postage		Nivram Management, Inc.	50.00%	490	490	19
20	V	20	Licenses & Permits		Nivram Management, Inc.	50.00%	116	116	20
21	V	25	Travel Expense		Nivram Management, Inc.	50.00%	1,946	1,946	21
22	V	30	Depreciation		Nivram Management, Inc.	50.00%	2,004	2,004	22
23	V	21	Data Processing		Nivram Management, Inc.	50.00%	805	805	23
24	V	21	Telephone Expense		Nivram Management, Inc.	50.00%	2,618	2,618	24
25	V	34	Rent Expense		Nivram Management, Inc.	50.00%	30,721	30,721	25
26	V	6	Plant Supervisor Salary		Nivram Management, Inc.	50.00%	77,145	77,145	26
27	V	17	Asst. Administrator Salary		Nivram Management, Inc.	50.00%	180,723	180,723	27
28	V	21	Office Manager Salary		Nivram Management, Inc.	50.00%	40,034	40,034	28
29	V	1	Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	25,000	25,000	29
30	V	17	Administrative Salaries		Nivram Management, Inc.	50.00%	106,669	106,669	30
31	V	17	Administrator Salary		Nivram Management, Inc.	50.00%	411,498	411,498	31
32	V	21	Clerical Salaries		Nivram Management, Inc.	50.00%	87,152	87,152	32
33	V	17	Management Fees	1,045,670	Nivram Management, Inc.	50.00%		(1,045,670)	33
34	V	34	Rental Income	30,721	Hamlin Arthur Building Partnership			(30,721)	34
35	V	21	Bank Fees		Hamlin Arthur Building Partnership		148	148	35
36	V	30	Depreciation Expense		Hamlin Arthur Building Partnership		7,518	7,518	36
37	V	19	Legal Fees		Hamlin Arthur Building Partnership		2,833	2,833	37
38	V	33	Real Estate Taxes		Hamlin Arthur Building Partnership		9,761	9,761	38
39	Total			\$ 1,076,391			\$ 1,004,772	\$ * (71,619)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	33	Real Estate Taxes	\$			\$ 228,321	\$ 228,321	15
16	V	34	Rental Income	1,864,921				(1,864,921)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,864,921			\$ 228,321	\$ * (1,636,600)	39

* 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
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16								16
17								17
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19								19
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21								21
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	162,137	13	33.33	Salary	\$ 81,068	17-7	1
2	Louise Mermelstein	Food Serv Superv	Support	0.00	50,000	6	33.33	Salary	25,000	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	148,857	6	34.13	Salary	77,145	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	80,069	13	33.33	Salary	40,034	21-7	4
5											5
6	Marvin Mermelstein	Administrative Asst.	Administrative	See Above	223,285	9	34.13	Salary	115,717	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	\$ 364,565		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# 0039966

Report Period Beginning:

01/01/2012Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Nivram Management, Inc.

Street Address

6500 N. Hamlin Avenue

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 679-7484

Fax Number

(847) 679-7494

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	25	Auto Expense	Resident Beds	624	3	\$ 432	\$ 213	\$ 147	1
2	20	Advertising	Resident Beds	624	3	855	213	292	2
3	21	Bank Charges	Resident Beds	624	3	93	213	32	3
4	6	Repairs & Maintenance	Resident Beds	624	3	7,644	213	2,609	4
5	5	Utilities	Resident Beds	624	3	17,638	213	6,021	5
6	21	Delivery Expense	Resident Beds	624	3	621	213	212	6
7	21	Donations	Resident Beds	624	3	285	213	97	7
8	21	Office Expense	Resident Beds	624	3	10,890	213	3,717	8
9	20	Dues & Subscriptions	Resident Beds	624	3	3,211	213	1,096	9
10	21	Taxes Other	Resident Beds	624	3	297	213	101	10
11	32	Interest Expense	Resident Beds	624	3	18	213	6	11
12	22	Payroll Taxes	Resident Beds	624	3	133,666	213	45,626	12
13	26	Insurance Expense	Resident Beds	624	3	3,520	213	1,202	13
14	22	Health Insurance	Resident Beds	624	3	47,658	213	16,268	14
15	7	Scavenger	Resident Beds	624	3	480	213	164	15
16	35	Rental Equipment	Resident Beds	624	3	2,499	213	853	16
17	2	Sales Taxes	Resident Beds	624	3	897	213	306	17
18	21	Postage	Resident Beds	624	3	1,435	213	490	18
19	20	Licenses & Fees	Resident Beds	624	3	339	213	116	19
20	25	Travel Expense	Resident Beds	624	3	5,702	213	1,946	20
21	30	Depreciation	Resident Beds	624	3	5,872	213	2,004	21
22	21	Data Processing	Resident Beds	624	3	2,358	213	805	22
23	21	Telephone Expense	Resident Beds	624	3	7,669	213	2,618	23
24	34	Rent Expense	Resident Beds	624	3	90,000	213	30,721	24
25	TOTALS					\$ 344,079	\$	\$ 117,449	25

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	Plant Supervisor Salary	Direct Cost	1	1	\$ 77,145	\$ 77,145	1	\$ 77,145	1
2	17	Asst. Administrator Salary	Direct Cost	1	1	180,723	180,723	1	180,723	2
3	21	Office Manager Salary	Direct Cost	1	1	40,034	40,034	1	40,034	3
4	1	Food Service Supervisor Salary	Direct Cost	1	1	25,000	25,000	1	25,000	4
5	17	Administrative Salaries	Direct Cost	1	1	106,669	106,669	1	106,669	5
6	17	Administrator Salary	Direct Cost	1	1	411,498	411,498	1	411,498	6
7	21	Clerical Salary	Direct Cost	1	1	87,152	87,152	1	87,152	7
8	21	Bank Fees	Resident Beds	624	3	434		213	148	8
9	30	Depreciation Expense	Resident Beds	624	3	22,025		213	7,518	9
10	19	Legal Fees	Resident Beds	624	3	8,298		213	2,832	10
11	33	Real Estate Taxes	Resident Beds	624	3	28,594		213	9,760	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					\$ 987,572	\$ 928,221		\$ 948,479	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	1,299		6
7													7
8													8
9	TOTAL Facility Related						\$ 230,765	\$			\$ 1,299		9
	B. Non-Facility Related*												
10	Offset Interest Income										(1,305)		10
11	Citi Credit Card		X	Financing	n/a	n/a	n/a	n/a	n/a	n/a	6		11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$ (1,299)		14
15	TOTALS (line 9+line14)						\$ 230,765	\$			\$		15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 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.)			\$	238,082	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(11,918)	3
4. Real Estate Tax accrual used for 2012 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.			\$	238,082	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	235,657	8	
		2008	238,021	9	
		2009	272,770	10	
		2010	284,645	11	
		2011	261,570	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2011 \$		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Balmoral Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039966

CONTACT PERSON REGARDING THIS REPORT

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 2011 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 2011.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 14-07-109-036-0000	Nursing Home	\$ 228,321.00	\$ 228,321.00
2. 10-35-325-029-0000	Management Co. Building	\$ 3,819.65	\$ 1,122.00
3. 10-35-325-015-0000	Management Co. Building	\$ 29,429.38	\$ 8,639.00
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 261,570.03	\$ 238,082.00

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,360

B. General Construction Type: Exterior BrickFrame SteelNumber 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 Nursing Home	33,375	1993	\$ 90,430	1
	2				2
	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	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1994	8,500	218	39	218		4,151	9
10	Fence			1994	2,700	69	39	69		1,247	10
11	Leasehold Improvements			1995	4,813	124	39	124		2,123	11
12	Leasehold Improvements			1996	3,750		10			3,750	12
13	Fire Alarm			1996	8,750	224	39	224		3,802	13
14	Laundry Chute			1996	2,181	56	39	56		945	14
15	Concrete Ramp			1996	2,500	64	39	64		1,054	15
16	Phone System			1993	4,475		5			4,475	16
17	Time Clock System			1993	1,853		7			1,853	17
18	Carpet			1993	1,144		7			1,144	18
19	Phone System			1994	2,967		7			2,967	19
20	Hot Water System			1995	3,035		7			3,035	20
21	Awning and Sign			1996	5,923	152	39	152		2,437	21
22	Parking Lot			1997	6,600	272	20	272		5,552	22
23	Remodeling Laundry Area			1997	5,400	139	39	139		2,198	23
24	Remodeling Laundry Area			1997	19,779	507	39	507		8,008	24
25	Handrails			1997	5,750	147	39	147		2,288	25
26	Fire Alarm			1997	16,726	429	39	429		6,698	26
27	Light Fixtures			1997	6,552	38	39	38		5,650	27
28	Boiler			1997	925	24	39	24		367	28
29	Kitchen Improvements			1997	2,875	74	39	74		1,135	29
30	Elevator			1997	2,300	59	39	59		897	30
31	Bathroom Remodeling			1997	312	8	39	8		121	31
32	HVAC, Boiler			1998	14,915	382	39	382		5,558	32
33	Ward Doors			1998	2,803	72	39	72		1,028	33
34	Concrete Steps			1998	2,500	64	39	64		931	34
35	Fire Alarm			1998	16,000	410	39	410		5,588	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 Balmoral Home

0039966

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Boiler and Duckwork	1999	\$ 18,500	\$ 474	39	\$ 474	\$	\$ 6,192	37
38	Windows	1999	1,498	39	39	39		531	38
39	Cooling Tower	2000	8,860	227	39	227		2,886	39
40	Heater	2000	3,000	77	39	77		939	40
41	Vestibule Remodeling	2001	4,200	108	39	108		1,299	41
42	Elevator	2002	1,500	39	39	39		420	42
43	Carpet	2002	1,500	39	39	39		420	43
44	A/C Unit	2003	24,800		5			24,800	44
45	Elevator Hydraulic Power Unit	2006	14,000	359	39	359		2,184	45
46	Water Heater	2006	3,900	100	39	100		600	46
47	Wet Che Suppression System	2006	2,225	57	39	57		342	47
48	Cooling Tower Slinger Assemble	2006	2,400	62	39	62		412	48
49	Motor Starter on Cooling Tower	2006	1,117	28	39	28		179	49
50	Pump Motor on Hot Water Heater	2006	1,406	36	39	36		249	50
51	Kitchen Exhaust Fan	2007	4,848	124	39	124		693	51
52	80 Ton Cooling Tower	2007	85,500	2,192	39	2,192		11,326	52
53	New Brick for Chimney	2007	5,500	141	39	141		729	53
54	Concret Stairs	2007	6,500	166	39	166		845	54
55	Sump Pump	2007	3,600	90	39	90		514	55
56	Water Heater	2008	5,200	133	39	133		543	56
57	Valves	2010	4,500	115	39	115		317	57
58	Sprinkler System Heads & Valves	2011	3,330	86	39	86		100	58
59	Elevator Project	2012	20,912	492	39	492		492	59
60	Pump	2012	2,500	21	39	21		21	60
61	Fire Dampers in Ducts	2012	5,000	53	39	53		53	61
62	Door Project	2012	58,002	248	39	248		248	62
63	Water Pump	2012	3,017	26	39	26		26	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,438,391	\$ 9,064		\$ 9,064	\$	\$ 1,121,410	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	\$ 895	\$	\$ (895)	5-7	\$ 25,666	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	198,256					198,256	73
74	Mng Company and R/E Prt		9,522	9,522				74
75	TOTALS	\$ 223,922	\$ 10,417	\$ 9,522	\$ (895)		\$ 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 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)	\$ 1,752,743	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,481	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,586	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (895)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,345,332	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: Annual Lease*

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$3,675Description: Copier - \$1,840; Ice Maker - \$982; Management Company - Copier - \$853.
(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	2012 Subaru Outback	\$509.00	\$6,108	17
18					18
19					19
20					20
21	TOTAL		\$509.00	\$6,108	21

10. Effective dates of current rental agreement:

Beginning01/01/2012

Ending12/31/2012

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.)

12345678										
	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	39-3	hrs			326,805			326,805	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): <u>Respiratory</u>	39-2					9,916		9,916	12
13	Other (specify): <u></u>									13
14	TOTAL			\$		\$ 326,805	\$ 9,916		\$ 336,721	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 268,901	\$ 268,901	1
2	Cash-Patient Deposits	37,681	37,681	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,903,840	2,903,840	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,751	80,751	6
7	Other Prepaid Expenses	589	589	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Loan</u>	2,154	2,154	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,293,916	\$ 3,293,916	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	406,267	406,267	15
16	Equipment, at Historical Cost	270,997	270,997	16
17	Accumulated Depreciation (book methods)	(358,495)	(1,343,543)	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)	\$ 318,769	\$ 409,199	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,612,685	\$ 3,703,115	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 205,781	\$ 205,781	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,686	37,686	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,858	114,858	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	13,948	13,948	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	2,661,600	2,661,600	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,033,873	\$ 3,033,873	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)	\$ 3,033,873	\$ 3,033,873	46
47	TOTAL EQUITY(page 18, line 24)	\$ 578,812	\$ 669,242	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,612,685	\$ 3,703,115	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 377,816	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 377,816	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,022,996	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	(1,822,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 200,996	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)	\$ 578,812	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,397,125	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,397,125	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,743	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,743	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule</u>	290,491	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 290,491	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,697,359	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,305,500	31
32	Health Care	2,423,802	32
33	General Administration	1,862,050	33
	B. Capital Expense		
34	Ownership	1,885,109	34
	C. Ancillary Expense		
35	Special Cost Centers	1,183,954	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,660,415	40
41	Income before Income Taxes (line 30 minus line 40)**	2,036,944	41
42	Income Taxes	(13,948)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,022,996	43

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

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 97,920	\$ 47.08	1
2	Assistant Director of Nursing	1,852	2,092	73,244	35.01	2
3	Registered Nurses	23,578	25,816	683,996	26.50	3
4	Licensed Practical Nurses	3,843	4,112	89,970	21.88	4
5	CNAs & Orderlies	73,551	78,383	771,148	9.84	5
6	CNA Trainees					6
7	Licensed Therapist	4,039	4,441	63,650	14.33	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,070	2,286	39,566	17.31	9
10	Activity Assistants	4,872	5,269	77,186	14.65	10
11	Social Service Workers	11,011	11,716	167,958	14.34	11
12	Dietician					12
13	Food Service Supervisor	2,036	2,359	49,861	21.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,297	24,638	260,086	10.56	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	14,234	15,623	156,340	10.01	18
19	Laundry	7,764	8,554	91,123	10.65	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,111	3,333	53,194	15.96	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	3,980	4,297	44,382	10.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,318	194,999	\$ 2,719,624 *	\$ 13.95	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	\$ 9,716	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	1,840	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	4,571	12-3	45
46	Other(specify) Psycho Social	S	177	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,304		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8,309	\$ 76,467	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8,309	\$ 76,467		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberBalmoral Home# 0039966Report Period Beginning: 01/01/2012Ending: 12/31/2012Page 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

\$ 1,045,670

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

(Attach a copy of any management service agreement)

\$ 1,045,670

C. Professional Services

Vendor/Payee

Type

Amount

\$

Attached Schedule

95,213

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

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

\$ 95,213

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 49,896

Unemployment Compensation Insurance

24,664

FICA Taxes

204,684

Employee Health Insurance

163,801

Employee Meals

37,248

Illinois Municipal Retirement Fund (IMRF)*

Union Pension

29,690

Employee Benefits

14,008

Allocation from Management Company

61,894

Entertainment Expense

(12,607)

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

\$ 573,278

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

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

(Indicate # of checks performed)

Patient Background Checks

10

1,200

Advertising and Promotions

9,630

Attached Schedule

4,332

Allocation from Management Company

1,504

Less: Public Relations Expense

()

Non-allowable advertising

(9,630)

Yellow page advertising

()

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

\$ 7,036

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

3,495

Entertainment Expense

()

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

TOTAL

\$ 3,495

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ No Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 847,233
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 37,248 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? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees