

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: <u>0039966</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Balmoral Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>2055 W Balmoral Ave</u> <u>Chicago</u> <u>60625</u>																																																			
Number City Zip Code																																																			
County: <u>Cook</u>																																																			
Telephone Number: <u>773-561-8661</u> Fax # <u>773-561-9373</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>10/10/93</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☒</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.	_____				☐	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact:																																																			
Name: <u>Mendel S Schneider</u>																																																			
Telephone Number: <u>847-933-1274</u>																																																			
Email Address: _____																																																			
		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>See Accountant's Report Attached</u></td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td colspan="2">(Firm Name & Address) <u>Mendel S Schneider & Associates CPA PC</u></td></tr><tr><td colspan="2"><u>4051 Old Orchard Rd Skokie Illinois 60076</u></td></tr><tr><td colspan="2">(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2">ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</td></tr><tr><td colspan="2">2200 Churchill Rd.</td></tr><tr><td colspan="2">Springfield, IL 62702-3406</td></tr><tr><td colspan="2">Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) <u>See Accountant's Report Attached</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Mendel S Schneider & Associates CPA PC</u>		<u>4051 Old Orchard Rd Skokie Illinois 60076</u>		(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>		MAIL TO: BUREAU OF HEALTH FINANCE		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES		2200 Churchill Rd.		Springfield, IL 62702-3406		Phone # (217) 782-1630																								
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Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA

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

	1	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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	4,323	50,270	3,795	233	1,562	1,641		61,824	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,323	50,270	3,795	233	1,562	1,641		61,824	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 79.52%

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

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

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

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

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 10/10/93

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 10/10/93 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 31

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	647,704	20,691	12,087	680,482		680,482		680,482			1
2	Food Purchase		438,004		438,004		438,004	(111)	437,893			2
3	Housekeeping	466,432	22,347	22,759	511,538		511,538		511,538			3
4	Laundry	32,022	5,976		37,998		37,998		37,998			4
5	Heat and Other Utilities			241,343	241,343		241,343	4,227	245,570			5
6	Maintenance	101,898		63,120	165,018		165,018	3,714	168,732			6
7	Other (specify):*											7
8	TOTAL General Services	1,248,056	487,018	339,309	2,074,383		2,074,383	7,830	2,082,213			8
	B. Health Care and Programs											
9	Medical Director			2,750	2,750		2,750		2,750			9
10	Nursing and Medical Records	3,634,279	105,866	872,018	4,612,163		4,612,163		4,612,163			10
10a	Therapy											10a
11	Activities	202,352	2,700		205,052		205,052		205,052			11
12	Social Services	256,689		4,335	261,024		261,024		261,024			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,093,320	108,566	879,103	5,080,989		5,080,989		5,080,989			16
	C. General Administration											
17	Administrative	125,000		1,024,305	1,149,305		1,149,305	(1,004,998)	144,307			17
18	Directors Fees											18
19	Professional Services			607,967	607,967		607,967	17,240	625,207			19
20	Dues, Fees, Subscriptions & Promotions			77,528	77,528		77,528	(20,571)	56,957			20
21	Clerical & General Office Expenses	255,108	65,598	168,705	489,411		489,411	931,826	1,421,237			21
22	Employee Benefits & Payroll Taxes			756,999	756,999		756,999		756,999			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,108	1,108		1,108		1,108			24
25	Other Admin. Staff Transportation			44,080	44,080		44,080	(44,080)				25
26	Insurance-Prop.Liab.Malpractice			207,437	207,437		207,437	3,610	211,047			26
27	Other (specify):* Allocated Benefits							50,486	50,486			27
28	TOTAL General Administration	380,108	65,598	2,888,129	3,333,835		3,333,835	(66,487)	3,267,348			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,721,484	661,182	4,106,541	10,489,207		10,489,207	(58,657)	10,430,550			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			32,059	32,059		32,059	29,610	61,669			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							376,371	376,371			33
34	Rent-Facility & Grounds			1,875,795	1,875,795		1,875,795	(1,875,795)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			207,865	207,865		207,865	(207,865)				36
37	TOTAL Ownership			2,115,719	2,115,719		2,115,719	(1,677,679)	438,040			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,250	655,737	756,987		756,987		756,987			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,050,567	1,050,567		1,050,567		1,050,567			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		101,250	1,706,304	1,807,554		1,807,554		1,807,554			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,721,484	762,432	7,928,564	14,412,480		14,412,480	(1,736,336)	12,676,144			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	29,610	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	(111)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(44,080)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(207,865)	36		24
25	Fund Raising, Advertising and Promotional	(3,904)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (226,356)		\$	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)	(1,493,313)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,493,313)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,719,669)		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	Political Action Committee Payments	\$ (16,667)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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45				45
46				46
47				47
48				48
49	Total	(16,667)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[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

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	34	Rent	\$ 1,875,795	Balmoral Trust	100.00%	\$	\$ (1,875,795)	1
2	V	33	Real Estate Taxes		Balmoral Trust		361,796	361,796	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,875,795			\$ 361,796	\$ * (1,513,999)	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	Payroll	\$	Nivram Mgmt Co	100.00%	\$ 455,009	\$ 455,009	15
16	V	27	Payroll Taxes		Nivram Mgmt Co		50,486	50,486	16
17	V	33	Real Estate Tax		Nivram Mgmt Co		14,575	14,575	17
18	V	5	Utilities		Nivram Mgmt Co		4,227	4,227	18
19	V	6	Repairs & Maintenance		Nivram Mgmt Co		3,714	3,714	19
20	V	26	Insurance		Nivram Mgmt Co		3,610	3,610	20
21	V	19	Professional Fees		Nivram Mgmt Co		17,240	17,240	21
22	V	21	Office		Nivram Mgmt Co		35,125	35,125	22
23	V	17	Marvin Mermelstein		Nivram Mgmt Co		19,307	19,307	23
24	V	21	Doreen Mermelstein		Nivram Mgmt Co		3,349	3,349	24
25	V	21	Jacob Mermelstein		Nivram Mgmt Co		132,637	132,637	25
26	V	21	Joel Mermelstein		Nivram Mgmt Co		132,923	132,923	26
27	V	21	Jeffrey Mermelstein		Nivram Mgmt Co		172,789	172,789	27
28	V	17	Management Fees	1,024,305	Nivram Mgmt Co			(1,024,305)	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			\$ 1,024,305			\$ 1,044,991	\$ * 20,686	39

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

Ownership Listing-1

ID# 0039966

12/31/2025

Balmoral Trust

Co. /Home Office

First Name

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VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Central Nursing Home	Chicago			Balmoral Trust	Lincolnwood, IL	Bldg Rental	1
2	Winston Manor Nursing Home	Chicago			Nivram Mgmt	Lincolnwood, IL	Mgmt	2
3	Paul House Health Care	Chicago						3
4								4
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6								6
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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	Marvin Mermelstein		Adm	50.00	48,495	10	25.00	Salary	\$ 19,307	17	1
2	Doreen Mermelstein		Clerical		8,411	10	25.00	Salary	3,349	21	2
3	Jacob Mermelstein		Clerical		333,149	10	25.00	Salary	132,637	21	3
4	Joel Mermelstein		Clerical		333,868	10	25.00	Salary	132,923	21	4
5	Jeffrey Mermelstein		Clerical		434,002	10	25.00	Salary	172,789	21	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 461,005		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: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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	21	Payroll	Resident Beds	748	4	\$ 1,597,872	\$ 1,597,872	213	\$ 455,009	1
2	27	Payroll Taxes	Resident Beds	748	4	177,295		213	50,486	2
3	33	Real Estate Tax	Resident Beds	748	4	51,185		213	14,575	3
4	5	Utilities	Resident Beds	748	4	14,844		213	4,227	4
5	6	Repairs & Maintenance	Resident Beds	748	4	13,043		213	3,714	5
6	26	Insurance	Resident Beds	748	4	12,677		213	3,610	6
7	19	Professional Fees	Resident Beds	748	4	60,541		213	17,240	7
8	21	Office	Resident Beds	748	4	123,350		213	35,125	8
9	17	Marvin Mermelstein	Resident Beds	748	4	67,802	67,802	213	19,307	9
10	21	Doreen Mermelstein	Resident Beds	748	4	11,760	11,760	213	3,349	10
11	21	Jacob Mermelstein	Resident Beds	748	4	465,786	230,442	213	132,637	11
12	21	Joel Mermelstein	Resident Beds	748	4	466,791	231,447	213	132,923	12
13	21	Jeffrey Mermelstein	Resident Beds	748	4	606,791	371,447	213	172,789	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,669,737	\$ 2,510,770		\$ 1,044,991	25

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1	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
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	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Balmoral Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039966

CONTACT PERSON REGARDING THIS REPORT Rob Strukoff

TELEPHONE 847-941-0100 FAX #: 847-941-0101

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 14-07-109-036-0000		\$ 361,794.94	\$ 361,794.94
2.		\$	\$
3.		\$	\$
4.		\$	\$
5. Allocated from Mgmt Co		\$	\$
6. 10-35-325-015-0000		\$ 43,099.76	\$ 12,273.00
7. 10-35-325-029-0000		\$ 8,084.94	\$ 2,303.00
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 412,979.64	\$ 376,370.94

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,360B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 3

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases?
H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement?
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	33,375		1993		\$ 90,430	
2							
3	TOTALS	33,375				\$ 90,430	

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		\$ 985,048	\$	39	\$	\$	\$ 985,048	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1994	8,500		39			8,500	9
10	Fence			1994	2,700		39			2,700	10
11	Leasehold Improvements			1995	4,813		39			4,813	11
12	Leasehold Improvements			1996	3,750		10			3,750	12
13	Fire Alarm			1996	8,750		39			8,750	13
14	Laundry Chute			1996	2,181		39			2,181	14
15	Concrete Ramp			1996	2,500		39			2,500	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 & Sign			1996	5,923		39			5,923	21
22	Parking Lot			1997	6,600		20			6,600	22
23	Remodeling Laundry Area			1997	5,400		39			5,400	23
24	Remodeling Laundry Area			1997	19,779		39			19,779	24
25	Handrails			1997	5,750		39			5,750	25
26	Fire Alarm			1997	16,726		39	441	441	16,726	26
27	Light Fixtures			1997	6,552		39			6,552	27
28	Boiler			1997	925		39			925	28
29	Kitchen Improvements			1997	2,875		39			2,875	29
30	Elevator			1997	2,300		39	23	23	2,300	30
31	Bathroom Remodeling			1997	312		39			312	31
32	Ward Doors			1998	2,803		39	102	102	2,782	32
33	Concrete Steps			1998	2,500		39	87	87	2,500	33
34	Fire Alarm			1998	16,000		39	582	582	15,594	34
35	Boiler & Duckwork			1998	18,500		39	673	673	18,136	35
36	Windows			1999	1,498		39	55	55	1,461	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:

01/01/2025

Ending:

12/31/2025

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

1	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	Cooling Tower	2000	\$ 8,860	\$	39	\$ 322	\$ 322	\$ 8,281	37
38	Heater	2000	3,000		39	109	109	2,749	38
39	Vestibule Remodeling	2001	4,200		39	153	153	3,826	39
40	Elevator	2002	1,500		39	55	55	1,303	40
41	Carpet	2002	1,500		39	55	55	1,303	41
42	A/C Unit	2003	24,800		5			24,800	42
43	Elevator Hydraulic Power Unit	2006	14,000		39	508	508	9,708	43
44	Wet Che Suppression Sys	2006	2,225		39	81	81	1,516	44
45	Ceiling Tower Slinger Assemble	2006	2,400		39	87	87	1,714	45
46	Motor Starter on Cooling Tower	2006	1,117		39	41	41	787	46
47	Kitchen Exhaust Fan	2007	4,848		39	176	176	3,273	47
48	80 Ton Cooling Tower	2007	85,500		39	3,101	3,101	56,425	48
49	New Brick for Chimney	2007	5,500		39	199	199	3,628	49
50	Concrete Stairs	2007	6,500		39	236	236	4,271	50
51	Valve	2010	4,500		39	163	163	2,574	51
52	Sprinkler System Heads & Valves	2011	3,330		39	121	121	1,715	52
53	Elevator Project	2012	20,912		39	762	762	10,595	53
54	Fire Dampers in Ducts	2012	5,000		39	182	182	2,437	54
55	Door Project	2012	58,002		39	2,113	2,113	27,797	55
56	Heating System	2013	51,200		39	1,865	1,865	23,295	56
57	Water Heater	2013	6,599		39	240	240	3,060	57
58	Water Heater	2013	10,800		39	392	392	4,773	58
59	Wiring Upgrade	2014	7,511		27.5	273	273	3,208	59
60	Fire Pump Phase Reversal	2015	4,350		27.5	158	158	1,713	60
61	Carpet	2016	6,150		27.5	224	224	2,089	61
62	PT Flooring	2017	8,200		27.5	298	298	2,583	62
63	Granite Counters	2017	13,000		27.5	473	473	4,020	63
64	Elevator Cylinder	2017	107,346		27.5	3,903	3,903	32,200	64
65	Dumb Waiter	2017	6,432		27.5	234	234	1,930	65
66	Elevator Project	2018	11,250		27.5	410	410	3,109	66
67	Carpet-First & Second Floor Corridor	2018	31,161		27.5	1,135	1,135	8,606	67
68	Grease Inceptor	2018	5,200		27.5	189	189	1,339	68
69	Kitchen Improvements/Pump	2019	25,383		15	1,692	1,692	10,998	69
70	TOTAL (lines 4 thru 69)		\$ 1,698,435	\$		\$ 21,913	\$ 21,913	\$ 1,416,956	70

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

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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

1	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	
1	Totals from Page 12A, Carried Forward		\$ 1,698,435	\$		\$ 21,913	\$ 21,913	\$ 1,416,956	1
2	Elevator Repair	2020	2,261		15	151	151	906	2
3	New Heat Timer ETV Platinum Plus with Electric Valve Shutoff	2020	11,272		15	751	751	4,506	3
4	60 Pound Rigid Milnor Washer	2021	27,839		15	1,856	1,856	9,280	4
5	Champion Roofing	2021	8,900		15	593	593	2,965	5
6	Access Point Installation Surveillance	2022	7,848		15	523	523	2,092	6
7	Install One Elevator Innovation Dumb Waiter	2022	75,372		15	5,025	5,025	20,100	7
8	Water Heater Replacement	2022	48,900		15	3,260	3,260	13,040	8
9	In-Line Inducer	2022	3,825		15	255	255	1,020	9
10	Plumbing Repair-Unclog Line	2023	1,839		15	123	123	369	10
11	2024 Improvements	2024							11
12	Install 2 Ton Condensing Unit in Elevator Room	2024	8,250		15	550	550	1,100	12
13	Install 5 4 inch Isolation Valve in Boiler Room	2024	9,500		15	633	633	1,266	13
14	Replacement of Fire Alarm Console by Nurses Station	2024	50,312		15	3,354	3,354	6,708	14
15	New Water Heater	2025	13,800		15	920	920	920	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Financial Statement Depreciation			32,059			(32,059)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,968,353	\$ 32,059		\$ 39,907	\$ 7,848	\$ 1,481,228	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$108,812	\$	\$21,762	\$21,762	5	\$85,748	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	284,515					284,515	73
74								74
75	TOTALS	\$393,327	\$	\$21,762	\$21,762		\$370,263	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)	\$2,452,110	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$32,059	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$61,669	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$29,610	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,851,491	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

* 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.

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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
		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)	\$			

- (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.

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	

- (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	39-3	hrs			655,737			655,737	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				101,250		101,250	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 655,737	\$ 101,250		\$ 756,987	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	\$ 581,685	\$ 581,685	1
2	Cash-Patient Deposits	380,966	380,966	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,997,986	2,997,986	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,816	57,816	6
7	Other Prepaid Expenses	70,241	70,241	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,088,694	\$ 4,088,694	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	948,217	948,217	15
16	Equipment, at Historical Cost	385,426	385,426	16
17	Accumulated Depreciation (book methods)	(1,002,714)	(1,987,762)	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)	\$ 330,929	\$ 421,359	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,419,623	\$ 4,510,053	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,726,071	\$ 1,726,071	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	394,330	394,330	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,461	156,461	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,189	4,189	31
32	Accrued Real Estate Taxes(Sch.IX-B)	786,000	786,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Acc Mgmt Fees</u>	3,550,898	3,550,898	36
37	<u>Credit Balances</u>	1,452,281	1,452,281	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,070,230	\$ 8,070,230	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,070,230	\$ 8,070,230	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,650,607)	\$ (3,560,177)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,419,623	\$ 4,510,053	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,401,771)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,401,771)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,751,164	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,751,164	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,650,607)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,154,868	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,154,868	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***	8,776	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,776	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,163,644	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,074,383	31
32	Health Care	5,080,989	32
33	General Administration	3,333,835	33
	B. Capital Expense		
34	Ownership	2,115,719	34
	C. Ancillary Expense		
35	Special Cost Centers	756,987	35
36	Provider Participation Fee	1,050,567	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,412,480	40
41	Income before Income Taxes (line 30 minus line 40)**	1,751,164	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,751,164	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 945,213.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	11,577,078.00	45
46	MMAI-Medicaid is the Primary Payer	837,345.00	46
47	MMAI-Medicare is the Primary Payer	158,406.00	47
48	Private Pay	445,970.00	48
49	Medicare Part A	1,367,980.00	49
50	Other-(specify) Medicare-B	822,876.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 16,154,868	56

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	2,251	2,379	\$ 120,875	\$ 50.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,976	20,885	1,000,874	47.92	3
4	Licensed Practical Nurses	4,538	4,887	189,080	38.69	4
5	CNAs & Orderlies	81,046	86,895	2,071,505	23.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,900	2,330	61,629	26.45	9
10	Activity Assistants	6,707	7,397	140,723	19.02	10
11	Social Service Workers	6,332	6,992	256,689	36.71	11
12	Dietician					12
13	Food Service Supervisor	2,258	2,482	114,633	46.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,694	25,259	533,071	21.10	15
16	Dishwashers					16
17	Maintenance Workers	3,557	3,844	101,898	26.51	17
18	Housekeepers	21,136	23,098	466,432	20.19	18
19	Laundry	1,593	1,720	32,022	18.62	19
20	Administrator	2,080	2,128	125,000	58.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,565	8,622	255,108	29.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,947	2,115	41,458	19.60	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	4,433	4,904	210,487	42.92	33
34	TOTAL (lines 1 - 33)	189,013	205,937	\$ 5,721,484 *	\$ 27.78	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	Monthly	\$ 12,087	1-3	35
36	Medical Director	Monthly	2,750	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	4,335	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,172		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,537	\$ 92,222	10-3	50
51	Licensed Practical Nurses	7,807	429,406	10-3	51
52	Certified Nurse Assistants/Aides	10,011	350,390	10-3	52
53	TOTAL (lines 50 - 52)	19,355	\$ 872,018		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Meir Stern	Administrator	0	\$ 125,000	Workers' Compensation Insurance	\$ 72,079	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	36,642	Advertising: Employee Recruitment		
				FICA Taxes	425,884	Health Care Worker Background Check	7,761	
				Employee Health Insurance	222,394	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	1,483	
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)	50,000	
						APPROI	3,600	
						Om Care LLC	3,180	
						Assured Manage Care	2,000	
						Various	3,610	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	()	
						PAC and Lobbying payments	(16,667)	
						All non-allowable advertising	()	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

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

Association Name

HEALTH CARE COUNCIL OF IL (HCCI)

Amount

33,333

33,333

Total

(3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)

16,667

16,667

Total

(4)

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

HEALTH CARE COUNCIL OF IL (HCCI)

50,000

50,000

Total

(5)

Indicate the total amount of both disposable and non-disposable incontinent expense
and the location of this expense on Sch. V.

\$ 22,500

Line 10

(6)

Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

Yes

If NO, attach a complete explanation.

(7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$ 1,050,567

This amount is to be recorded on line 42 of Schedule V.

(8)

Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee?

No

If YES, attach an explanation of the allocation.

(9)

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

Yes

(10)

Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B?

No

For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(11)

Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V.

\$

Has any meal income been offset against
related costs?

Indicate the amount. \$

(12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for
residents?

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

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

d. Have vehicle usage logs been maintained?

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

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

g. Does the facility transport residents to and from day training?

Indicate the amount of income earned from providing such
transportation during this reporting period. \$

(13)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

(14)

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

Yes

(15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.