

Facility Name & ID Number Balmoral Home

0039966 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 213

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>213</u>	Skilled (SNF)	<u>213</u>	<u>77,745</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>213</u>	TOTALS	<u>213</u>	<u>77,745</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>71,999</u>	<u>203</u>	<u>1,931</u>	<u>74,133</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>71,999</u>	<u>203</u>	<u>1,931</u>	<u>74,133</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.35%

D. How many bed-hold days during this year were paid by the Department? 1,521 (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 _____ 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 1,458

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	232,194	36,887	8,693	277,774		277,774	15,363	293,137		1
2	Food Purchase		248,531		248,531	(16,323)	232,208	(117)	232,091		2
3	Housekeeping	152,891	25,690		178,581		178,581		178,581		3
4	Laundry	77,155	7,301		84,456		84,456		84,456		4
5	Heat and Other Utilities			170,863	170,863		170,863	3,012	173,875		5
6	Maintenance		34,230	68,278	102,508		102,508	30,790	133,298		6
7	Other (specify):*			14,542	14,542		14,542		14,542		7
8	TOTAL General Services	462,240	352,639	262,376	1,077,255	(16,323)	1,060,932	49,048	1,109,980		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,679,974	90,205	2,631	1,772,810		1,772,810		1,772,810		10
10a	Therapy	41,825		469	42,294		42,294		42,294		10a
11	Activities	92,469	2,847		95,316		95,316		95,316		11
12	Social Services	130,970			130,970		130,970		130,970		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,945,238	93,052	3,100	2,041,390		2,041,390		2,041,390		16
	C. General Administration										
17	Administrative			451,763	451,763		451,763	(180,167)	271,596		17
18	Directors Fees										18
19	Professional Services			37,501	37,501		37,501		37,501		19
20	Dues, Fees, Subscriptions & Promotions			43,183	43,183		43,183	(22,209)	20,974		20
21	Clerical & General Office Expenses	41,655		33,481	75,136		75,136	80,669	155,805		21
22	Employee Benefits & Payroll Taxes			408,856	408,856	16,323	425,179	33,194	458,373		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,800	1,800		1,800		1,800		24
25	Other Admin. Staff Transportation			706	706		706	855	1,561		25
26	Insurance-Prop.Liab.Malpractice			181,661	181,661		181,661	669	182,330		26
27	Other (specify):* Medical Records	32,470			32,470		32,470		32,470		27
28	TOTAL General Administration	74,125		1,158,951	1,233,076	16,323	1,249,399	(86,989)	1,162,410		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,481,603	445,691	1,424,427	4,351,721		4,351,721	(37,941)	4,313,780		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Balmoral Home

#0039966

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			16,738	16,738		16,738	7,208	23,946			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,461	4,461		4,461	(4,461)				32
33	Real Estate Taxes							256,820	256,820			33
34	Rent-Facility & Grounds			1,500,740	1,500,740		1,500,740	(1,500,740)				34
35	Rent-Equipment & Vehicles			10,265	10,265		10,265	624	10,889			35
36	Other (specify):*											36
37	TOTAL Ownership			1,532,204	1,532,204		1,532,204	(1,240,549)	291,655			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,554	35,950	43,504		43,504		43,504			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,618	116,618		116,618		116,618			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		7,554	152,568	160,122		160,122		160,122			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,481,603	453,245	3,109,199	6,044,047		6,044,047	(1,278,490)	4,765,557			45

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

Facility Name & ID Number **Balmoral Home**

0039966

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	7,208	30		9
10	Interest and Other Investment Income	(4,461)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(117)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(150)	21		20
21	Owner or Key-Man Insurance	(836)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,554)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(17,128)	20		28
29	Other-Attach Schedule <u>See Attached Schedule</u>	(4,804)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (34,842)		\$	30

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	2	
		Amount	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	(1,243,648)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,243,648)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,278,490)		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	2	3	4
		Yes	No	Amount	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	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

Balmoral Home

ID# 0039966

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Deductible Dues	\$ (3,531)	20	1
2	Franchise Tax	(256)	21	2
3	Trust Fee	(75)	21	3
4	Franchise Tax - Management Company	(25)	21	4
5	Background Checks, Paid on behave of other			5
6	related entities and as a result non-allowable	(1,680)	20	6
7	Gas purchased by related entity and properly			7
8	allocated to this facility	925	25	8
9	Personal Auto Use Portion	(162)	25	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,804)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Balmoral Home# 0039966 Report Period Beginning:

01/01/2006

Ending: 12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	15,363	0	0	0	0	0	0	0	0	15,363	1
2	Food Purchase	(117)	0	0	0	0	0	0	0	0	0	0	(117)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,012	0	0	0	0	0	0	0	0	0	3,012	5
6	Maintenance	0	1,377	29,413	0	0	0	0	0	0	0	0	30,790	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(117)	4,389	44,776	0	49,048	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(180,167)	0	0	0	0	0	0	0	0	(180,167)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(22,339)	130	0	0	0	0	0	0	0	0	0	(22,209)	20
21	Clerical & General Office Expenses	(15,060)	1,455	94,274	0	0	0	0	0	0	0	0	80,669	21
22	Employee Benefits & Payroll Taxes	(836)	34,030	0	0	0	0	0	0	0	0	0	33,194	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	763	92	0	0	0	0	0	0	0	0	0	855	25
26	Insurance-Prop.Liab.Malpractice	0	669	0	0	0	0	0	0	0	0	0	669	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(37,472)	36,376	(85,893)	0	(86,989)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,589)	40,765	(41,117)	0	(37,941)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,208	0	0	0	0	0	0	0	0	0	0	7,208	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,461)	0	0	0	0	0	0	0	0	0	0	(4,461)	32
33	Real Estate Taxes	0	0	256,820	0	0	0	0	0	0	0	0	256,820	33
34	Rent-Facility & Grounds	0	0	(1,500,740)	0	0	0	0	0	0	0	0	(1,500,740)	34
35	Rent-Equipment & Vehicles	0	624	0	0	0	0	0	0	0	0	0	624	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,747	624	(1,243,920)	0	(1,240,549)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(34,842)	41,389	(1,285,037)	0	(1,278,490)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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, IL	Nivram Mngt, Inc.	Lincolnwood, IL	Management
Joseph Mermelstein	50.00	Central Nursing Home	Chicago, IL			
		Chicago Ridge Nursing & Rehab Center	Chicago Ridge, IL			

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	21	Bank Charges	Nivram Management, Inc.	50.00%	\$ 20	\$ 20	1	
2	V	21	Office Expense	Nivram Management, Inc.	50.00%	775	775	2	
3	V	20	Dues & Subscriptions	Nivram Management, Inc.	50.00%	130	130	3	
4	V	21	Franchise Tax	Nivram Management, Inc.	50.00%	25	25	4	
5	V	22	Payroll Tax	Nivram Management, Inc.	50.00%	31,640	31,640	5	
6	V	5	Utilities	Nivram Management, Inc.	50.00%	3,012	3,012	6	
7	V	26	Insurance	Nivram Management, Inc.	50.00%	669	669	7	
8	V	6	Repairs & Maintenance	Nivram Management, Inc.	50.00%	1,132	1,132	8	
9	V	22	Health Insurance	Nivram Management, Inc.	50.00%	2,390	2,390	9	
10	V	6	Scavenger	Nivram Management, Inc.	50.00%	245	245	10	
11	V	35	Rental Equipment	Nivram Management, Inc.	50.00%	624	624	11	
12	V	25	Auto Expense	Nivram Management, Inc.	50.00%	92	92	12	
13	V	21	Postage	Nivram Management, Inc.	50.00%	635	635	13	
14	Total		\$			\$ 41,389	\$ *	41,389	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 Data Processing	\$	Nivram Management, Inc.	50.00%	\$ 396	\$	396	15
16	V	21 Telephone		Nivram Management, Inc.	50.00%	1,238		1,238	16
17	V	6 Plant Supervisor Salary		Nivram Management, Inc.	50.00%	29,413		29,413	17
18	V	17 Asst Administrator Salary		Nivram Management, Inc.	50.00%	55,658		55,658	18
19	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	18,105		18,105	19
20	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	15,363		15,363	20
21	V	17 Administrative Salary		Nivram Management, Inc.	50.00%	65,938		65,938	21
22	V	17 Administrator Salary		Nivram Management, Inc.	50.00%	150,000		150,000	22
23	V	21 Clerical Salaries		Nivram Management, Inc.	50.00%	74,535		74,535	23
24	V	17 Management Fee	451,763	Nivram Management, Inc.	50.00%			(451,763)	24
25	V	34 Rent	1,500,740					(1,500,740)	25
26	V	33 Real Estate Tax Expense				256,820		256,820	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		\$ 1,952,503			\$ 667,466	\$ *	(1,285,037)	39

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

Facility Name & ID Number

Balmoral Home

#

0039966

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	232,347	6	15.51	Salary	\$ 42,653	17-1	1
2	Louise Mermelstein	Food Serv. Superv.	Support	0.00	74,637	7	17.07	Salary	15,363	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	90,587	4	24.51	Salary	29,413	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	85,455	7	17.48	Salary	18,105	21-7	4
5											5
6	Marvin Mermelstein	Administrative Asst.	Administrative	See Above	135,880	7	24.51	Salary	44,120	17-7	6
7	Joseph Mermelstein	Owner	Administrative	50.00	71,715	3	24.51	Salary	23,285	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 172,939		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: 01/01/2006 Ending: 2/31/2006

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 Ave.
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-7484
 Fax Number (847) 679-7494

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	869	4	\$ 80	\$ 213	\$ 20	1
2	21	Office Expenses	Resident Beds	869	4	3,160	213	775	2
3	20	Dues & Subscriptions	Resident Beds	869	4	530	213	130	3
4	21	Franchise Tax	Resident Beds	869	4	100	213	25	4
5	22	Payroll Tax	Resident Beds	869	4	129,086	213	31,640	5
6	5	Utilities	Resident Beds	869	4	12,288	213	3,012	6
7	26	Insurance	Resident Beds	869	4	2,728	213	669	7
8	6	Repairs & Maintenance	Resident Beds	869	4	4,620	213	1,132	8
9	22	Health Insurance	Resident Beds	869	4	9,750	213	2,390	9
10	6	Scavenger	Resident Beds	869	4	1,000	213	245	10
11	35	Rental Equipment	Resident Beds	869	4	2,544	213	624	11
12	25	Auto Expense	Resident Beds	869	4	374	213	92	12
13	21	Postage	Resident Beds	869	4	2,591	213	635	13
14	21	Data Processing	Resident Beds	869	4	1,616	213	396	14
15	21	Telephone	Direct Cost	869	4	5,049	213	1,238	15
16	6	Plant Salary	Direct Cost	1	1	29,413	1	29,413	16
17	17	Asst Administrator Salary	Direct Cost	1	1	55,658	1	55,658	17
18	21	Office Manager Salary	Direct Cost	1	1	18,105	1	18,105	18
19	1	Food Service Supervisor Salary	Direct Cost	1	1	15,363	1	15,363	19
20	17	Administrative Salaries	Direct Cost	1	1	65,938	1	65,938	20
21	21	Administrator Salary	Direct Cost	1	1	150,000	1	150,000	21
22	17	Clerical Salaries	Direct Cost	1	1	74,535	1	74,535	22
23									23
24									24
25	TOTALS					\$ 584,528	\$	\$ 452,035	25

Facility Name & ID Number

Balmoral Home

0039966

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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		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		X	Line of Credit	N/A	2/28/06	199,000		2/28/07	7.5000	4,461	6						
7	Offset Interest Income										(4,461)	7						
8												8						
9	TOTAL Facility Related						\$ 199,000	\$			\$	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 199,000	\$			\$	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 2005 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.)	\$	256,820	2
3. Under or (over) accrual (line 2 minus line 1).	\$	6,820	3
4. Real Estate Tax accrual used for 2006 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.	\$	256,820	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	243,052	8
	2002	245,777	9
	2003	248,707	10
	2004	254,232	11
	2005	256,820	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Balmoral Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039966

CONTACT PERSON REGARDING THIS REPORT Sanford B Alper

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-07-109-036-0000</u>	<u>Nursing Home</u>	\$ <u>256,820.00</u>	\$ <u>256,820.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>256,820.00</u>	\$ <u>256,820.00</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,360 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

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

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

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	\$	30	\$	\$	\$ 985,048	4
5				(35,470)						5
6										6
7										7
8										8
	Improvement Type**									
9	Leasehold Improvements		1994	8,500	218	35	243	25	3,078	9
10	Fence		1994	2,700	69	35	77	8	899	10
11	Leasehold Improvements		1995	4,813	123	10		(123)	4,813	11
12	Leasehold Improvements		1995	3,750		10			3,750	12
13	Fire Alarm		1996	8,750	225	15	584	359	6,229	13
14	Laundry Chute		1996	2,181	56	15	146	90	1,557	14
15	Concrete Ramp		1996	2,500	64	35	72	8	768	15
16	Phone System		1993	4,475		5			4,475	16
17	Time Clock System		1993	1,853		5			1,853	17
18	Carpet		1993	1,144		5			1,144	18
19	Phone System		1994	2,967		5			2,967	19
20	Hot Water System		1995	3,035		5			3,035	20
21	Awning and Signs		1996	5,923	152	39	152		1,469	21
22	Parking Lot		1997	6,600	272	15	440	168	4,253	22
23	Remodeling Laundry Area		1997	5,400	139	7		(139)	5,400	23
24	Remodeling Laundry Area		1997	19,779	507	7		(507)	19,779	24
25	Handrails		1997	5,750	147	7		(147)	5,750	25
26	Fire Alarm		1997	16,726	429	7		(429)	16,726	26
27	Light Fixtures		1997	6,552	38	7		(38)	6,552	27
28	Boiler		1997	925	24	7		(24)	925	28
29	Kitchen Improvements		1997	2,875	74	7		(74)	2,875	29
30	Elevator		1997	2,300	59	7		(59)	2,300	30
31	Bathroom Remodeling		1997	312	8	7		(8)	312	31
32	HVAC, Boiler		1998	14,915	382	7		(382)	14,915	32
33	Ward Doors		1998	2,803	71	35	80	9	693	33
34	Concrete Steps		1998	2,500	64	35	71	7	616	34
35	Fire Alarm		1999	16,000	410	10	1,600	1,190	12,267	35
36										36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 475	10	\$ 1,850	\$ 1,375	\$ 12,518	37
38	Windows	1999	1,498	38	10	150	112	1,150	38
39	Cooling Tower	2000	8,860	227	10	886	659	5,907	39
40	Heater	2000	3,000	76	10	300	224	2,000	40
41	Vestibule Remodeling	2001	4,200	107	39	107		600	41
42	Elevator	2002	1,500	38	39	38		171	42
43	Carpet	2002	1,500	38	39	38		171	43
44	A/C Unit	2003	24,800	2,000	39	636	(1,364)	2,226	44
45	Elevator Hydraulic Power Unit	2006	14,000	30	39	179	149	179	45
46	Water Heater	2006	3,900		39	50	50	50	46
47	Wet Chem Suppression System	2006	2,225		39	29	29	29	47
48	Cooling Tower Slinger Assembly	2006	2,400	41	39	31	(10)	31	48
49	Motor Starter on Colling Tower	2006	1,117	10	39	14	4	14	49
50	Pump Motor on Hot Water Heater	2006	1,406	33	39	18	(15)	18	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,194,512	\$ 6,644		\$ 7,791	\$ 1,147	\$ 1,139,512	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 130,407	\$ 6,966	\$ 13,041	\$ 6,075	10	\$ 72,919	71
72	Current Year Purchases	7,105	479	355	(124)	10	355	72
73	Fully Depreciated Assets	68,849				10	68,849	73
74	Management Company					10		74
75	TOTALS	\$ 206,361	\$ 7,445	\$ 13,396	\$ 5,951		\$ 142,123	75

D. Vehicle Depreciation (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	Administrative	1999 Infiniti I30 (Used)	2004	\$ 13,795	\$ 2,649	\$ 2,759	\$ 110	5	\$ 8,277	76
77										77
78										78
79										79
80	TOTALS			\$ 13,795	\$ 2,649	\$ 2,759	\$ 110		\$ 8,277	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)	\$ 1,505,098	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,738	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,946	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,208	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,289,912	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 3,317 Description: Copier - \$2,417; Icemaker - \$900

(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	2005 Chevy Tahoe	\$ 579.00	\$ 6,948	17
18					18
19					19
20					20
21	TOTAL		\$ 579.00	\$ 6,948	21

10. Effective dates of current rental agreement:

Beginning 01/01/2006

Ending 12/31/2006

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

Fiscal Year Ending Annual Rent

12. /2007 \$ _____

13. /2008 \$ _____

14. /2009 \$ _____

* 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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	35,950					35,950	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Attached Sch</u>						7,554		7,554	13
14	TOTAL			\$ 35,950		\$	\$ 7,554		\$ 43,504	14

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

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 594,987	\$ 625,070	1
2	Cash-Patient Deposits	27,845	27,845	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	151,611	151,611	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,527	103,527	6
7	Other Prepaid Expenses	28,372	28,372	7
8	Accounts Receivable (owners or related parties)		70,852	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 906,342	\$ 1,007,277	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	197,858	197,858	15
16	Equipment, at Historical Cost	267,232	356,139	16
17	Accumulated Depreciation (book methods)	(286,516)	(1,360,471)	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)	\$ 178,574	\$ 269,004	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,084,916	\$ 1,276,281	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 73,578	\$ 63,496	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,845	27,845	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,210	52,210	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	250,000	250,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	484,553	2,066,403	36
37	Due to BCBS		241	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 888,186	\$ 2,460,195	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)	\$ 888,186	\$ 2,460,195	46
47	TOTAL EQUITY(page 18, line 24)	\$ 196,730	\$ (1,183,914)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,084,916	\$ 1,276,281	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (322,360)	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (322,357)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,115,287	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	(596,200)	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)	\$ 519,087	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)	\$ 196,730	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,996,761	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,996,761	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,036	6
7	Oxygen	27,158	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 90,194	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	9,682	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,590	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,272	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	43,973	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 43,973	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	5,610	28
28a	<u>Miscellaneous Income</u>	6,538	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,148	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,159,348	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,077,255	31
32	Health Care	2,041,390	32
33	General Administration	1,233,076	33
	B. Capital Expense		
34	Ownership	1,532,204	34
	C. Ancillary Expense		
35	Special Cost Centers	43,504	35
36	Provider Participation Fee	116,618	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,044,047	40
41	Income before Income Taxes (line 30 minus line 40)**	1,115,301	41
42	Income Taxes	(14)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,115,287	43

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

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

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

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

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,960	2,080	\$ 89,250	\$ 42.91	1
2	Assistant Director of Nursing	1,909	2,069	64,120	30.99	2
3	Registered Nurses	28,801	30,537	770,466	25.23	3
4	Licensed Practical Nurses	4,089	4,305	81,719	18.98	4
5	CNAs & Orderlies	71,568	74,444	674,419	9.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,215	4,431	41,825	9.44	8
9	Activity Director	2,017	2,225	30,937	13.90	9
10	Activity Assistants	4,275	4,515	61,532	13.63	10
11	Social Service Workers	10,239	10,647	130,970	12.30	11
12	Dietician					12
13	Food Service Supervisor	3,036	3,195	42,523	13.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,255	21,701	189,671	8.74	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	16,648	17,824	152,891	8.58	18
19	Laundry	8,018	8,626	77,155	8.94	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,182	3,343	41,655	12.46	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	2,590	2,790	32,470	11.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,802	192,732	\$ 2,481,603 *	\$ 12.88	34

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

** See instructions.

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	\$ 8,693	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	2,631	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L	110	10a-3	40
41	Occupational Therapy Consultant	Y	359	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E			45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 11,793		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
			\$	Workers' Compensation Insurance	\$ 53,236	IDPH License Fee	\$ 1,990			
				Unemployment Compensation Insurance	37,738	Advertising: Employee Recruitment				
				FICA Taxes	188,033	Health Care Worker Background Check				
				Employee Health Insurance	89,095	(Indicate # of checks performed 82)	820			
				Employee Meals	16,323	Patient Background Checks	2,920			
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Page Advertising	17,128			
				Union Pension	20,351	See Attached Schedule	15,114			
				Other Employee Benefits	19,567	Allocation from Management Company	130			
				Allocation from Management Company	34,030					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$							
B. Administrative - Other										
Description			Amount							
Management Fees			\$ 451,763							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 451,763	TOTAL (agree to Schedule V, line 22, col.8)			\$ 458,373			
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount		
See Attached Schedule 21-C			\$ 37,501				Out-of-State Travel	\$		
							In-State Travel			
							Seminar Expense	1,800		
							Entertainment Expense	()		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 37,501	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,800

* Attach copy of IMRF notifications

**See instructions.

