

Facility Name & ID Number Balmoral Home

0039966 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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>77,958</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>213</u>	TOTALS	<u>213</u>	<u>77,958</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>69,165</u>	<u>150</u>	<u>4,362</u>	<u>73,677</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>69,165</u>	<u>150</u>	<u>4,362</u>	<u>73,677</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.51%

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

1,805 (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 4,188

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	258,074	25,471	40,338	323,883		323,883	16,899	340,782		1
2	Food Purchase		312,775		312,775	(44,052)	268,723	(392)	268,331		2
3	Housekeeping	150,683	47,912		198,595		198,595		198,595		3
4	Laundry	80,858	12,861		93,719		93,719		93,719		4
5	Heat and Other Utilities			210,267	210,267		210,267	3,822	214,089		5
6	Maintenance		46,310	66,175	112,485		112,485	34,270	146,755		6
7	Other (specify):* Schedule Attached			20,255	20,255		20,255		20,255		7
8	TOTAL General Services	489,615	445,329	337,035	1,271,979	(44,052)	1,227,927	54,599	1,282,526		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,662,097	208,494	50,895	1,921,486		1,921,486		1,921,486		10
10a	Therapy	42,630			42,630		42,630		42,630		10a
11	Activities	115,734	2,795		118,529		118,529		118,529		11
12	Social Services	137,325		3,801	141,126		141,126		141,126		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,957,786	211,289	54,696	2,223,771		2,223,771		2,223,771		16
	C. General Administration										
17	Administrative			479,874	479,874		479,874	(186,565)	293,309		17
18	Directors Fees										18
19	Professional Services			73,920	73,920		73,920	6,464	80,384		19
20	Dues, Fees, Subscriptions & Promotions			60,026	60,026	1,000	61,026	(28,346)	32,680		20
21	Clerical & General Office Expenses	43,601		25,132	68,733	(1,000)	67,733	87,322	155,055		21
22	Employee Benefits & Payroll Taxes			401,223	401,223	44,052	445,275	35,522	480,797		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,250	1,250		1,250	190	1,440		24
25	Other Admin. Staff Transportation			897	897		897	(90)	807		25
26	Insurance-Prop.Liab.Malpractice			115,581	115,581		115,581	428	116,009		26
27	Other (specify):* Bad Debts			10,376	10,376		10,376	(10,376)			27
28	TOTAL General Administration	43,601		1,168,279	1,211,880	44,052	1,255,932	(95,451)	1,160,481		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,491,002	656,618	1,560,010	4,707,630		4,707,630	(40,852)	4,666,778		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:

01/01/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			23,604	23,604		23,604	(1,013)	22,591			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							235,657	235,657			33
34	Rent-Facility & Grounds			1,479,577	1,479,577		1,479,577	(1,479,577)				34
35	Rent-Equipment & Vehicles			12,868	12,868		12,868	(122)	12,746			35
36	Other (specify):*											36
37	TOTAL Ownership			1,516,049	1,516,049		1,516,049	(1,245,055)	270,994			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,946	215,794	217,740		217,740		217,740			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,938	116,938		116,938		116,938			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,946	332,732	334,678		334,678		334,678			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,491,002	658,564	3,408,791	6,558,357		6,558,357	(1,285,907)	5,272,450			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(1,195)	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	(392)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(135)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,088)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(750)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,376)	27		24
25	Fund Raising, Advertising and Promotional	(19,726)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(120)	20		28
29	Other-Attach Schedule	(8,204)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,986)		\$	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)	(1,243,921)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,243,921)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,285,907)		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						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	

Balmoral Home

ID# 0039966

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Deductible Dues	\$ (7,930)	20	1
2	Franchise Tax	(178)	21	2
3	Trust Fee	(75)	21	3
4	Franchise Tax - Management Company	(25)	21	4
5	2008 Seminar Paid in 2007	190	24	5
6	Chicago Head Tax Paid by Affiliated Company	1,092	22	6
7	Copier Rental Paid for Chgo Ridge Nursing Home	(558)	35	7
8	Worker Background Checks for Affiliated Homes	(870)	20	8
9	Resident Background Checks Paid by Other Homes	150	20	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	(8,204)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Balmoral Home# 0039966

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	16,899	0	0	0	0	0	0	0	0	16,899	1
2	Food Purchase	(392)	0	0	0	0	0	0	0	0	0	0	(392)	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	3,822	0	0	0	0	0	0	0	0	0	3,822	5
6	Maintenance	0	1,916	32,354	0	0	0	0	0	0	0	0	34,270	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(392)	5,738	49,253	0	54,599	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	(186,565)	0	0	0	0	0	0	0	0	(186,565)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	6,464	0	0	0	0	0	0	0	0	6,464	19
20	Fees, Subscriptions & Promotions	(28,496)	113	37	0	0	0	0	0	0	0	0	(28,346)	20
21	Clerical & General Office Expenses	(1,366)	2,134	86,554	0	0	0	0	0	0	0	0	87,322	21
22	Employee Benefits & Payroll Taxes	342	35,180	0	0	0	0	0	0	0	0	0	35,522	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	190	0	0	0	0	0	0	0	0	0	0	190	24
25	Other Admin. Staff Transportation	(135)	45	0	0	0	0	0	0	0	0	0	(90)	25
26	Insurance-Prop.Liab.Malpractice	0	428	0	0	0	0	0	0	0	0	0	428	26
27	Other (specify):*	(10,376)	0	0	0	0	0	0	0	0	0	0	(10,376)	27
28	TOTAL General Administration	(39,841)	37,900	(93,510)	0	(95,451)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(40,233)	43,638	(44,257)	0	(40,852)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Balmoral Home# 0039966

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,195)	0	182	0	0	0	0	0	0	0	0	(1,013)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	235,657	0	0	0	0	0	0	0	0	235,657	33
34	Rent-Facility & Grounds	0	0	(1,479,577)	0	0	0	0	0	0	0	0	(1,479,577)	34
35	Rent-Equipment & Vehicles	(558)	436	0	0	0	0	0	0	0	0	0	(122)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,753)	436	(1,243,738)	0	(1,245,055)	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)	(41,986)	44,074	(1,287,995)	0	(1,285,907)	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	Nivram Mngmt, Inc.	Lincolnwood	Management
Joseph Mermelstein Trust	50.00	Central Nursing Home	Chicago			
		Chicago Ridge Nursing & Rehab Center	Chicago Ridge			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	21 Delivery Expense	\$	Nivram Management, Inc.	50.00%	\$ 540	\$	540	1
2	V	21 Office Expenses		Nivram Management, Inc.	50.00%	1,046		1,046	2
3	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	113		113	3
4	V	21 Franchise Tax		Nivram Management, Inc.	50.00%	25		25	4
5	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	32,119		32,119	5
6	V	5 Utilities		Nivram Management, Inc.	50.00%	3,822		3,822	6
7	V	26 Insurance		Nivram Management, Inc.	50.00%	428		428	7
8	V	6 Repairs & Maintenance		Nivram Management, Inc.	50.00%	1,784		1,784	8
9	V	22 Health Insurance		Nivram Management, Inc.	50.00%	3,061		3,061	9
10	V	6 Scavenger		Nivram Management, Inc.	50.00%	132		132	10
11	V	35 Equipment Rental		Nivram Management, Inc.	50.00%	436		436	11
12	V	25 Auto Expense		Nivram Management, Inc.	50.00%	45		45	12
13	V	21 Postage		Nivram Management, Inc.	50.00%	523		523	13
14	Total		\$ 5,883			\$ 44,074	\$ *	44,074	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	19 <u>Legal & Accounting</u>	\$	<u>Nivram Management, Inc.</u>	50.00%	\$ 5,883	\$	5,883	15
16	V	20 <u>Licenses & Permits</u>		<u>Nivram Management, Inc.</u>	50.00%	37		37	16
17	V	30 <u>Depreciation</u>		<u>Nivram Management, Inc.</u>	50.00%	182		182	17
18	V	19 <u>Data Processing</u>		<u>Nivram Management, Inc.</u>	50.00%	581		581	18
19	V	21 <u>Telephone</u>		<u>Nivram Management, Inc.</u>	50.00%	1,907		1,907	19
20	V	17 <u>Management Fees</u>	479,874	<u>Nivram Management, Inc.</u>	50.00%			(479,874)	20
21	V	34 <u>Rent</u>	1,479,577	<u>Marvin Mermelstein</u>				(1,479,577)	21
22	V	33 <u>Real Estate Taxes</u>		<u>Marvin Mermelstein</u>		235,657		235,657	22
23	V	6 <u>Plant Supervisor Salary</u>		<u>Nivram Management, Inc.</u>	50.00%	32,354		32,354	23
24	V	17 <u>Asst. Administrator Salaries</u>		<u>Nivram Management, Inc.</u>	50.00%	100,840		100,840	24
25	V	21 <u>Office Manager Salary</u>		<u>Nivram Management, Inc.</u>	50.00%	19,912		19,912	25
26	V	1 <u>Food Service Supervisor Salary</u>		<u>Nivram Management, Inc.</u>	50.00%	16,899		16,899	26
27	V	17 <u>Administrative Salaries</u>		<u>Nivram Management, Inc.</u>	50.00%	72,532		72,532	27
28	V	17 <u>Administrator Salary</u>		<u>Nivram Management, Inc.</u>	50.00%	119,937		119,937	28
29	V	21 <u>Clerical Salaries</u>		<u>Nivram Management, Inc.</u>	50.00%	64,735		64,735	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		\$ 1,959,451			\$ 671,456	\$ *	(1,287,995)	39

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

Facility Name & ID Number

Balmoral Home

0039966

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	255,582	6	16.00	Salary	\$ 46,918	17-7	1
2	Louise Mermelstein	Food Serv Supervsr	Support	0.00	82,101	7	17.00	Salary	16,899	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	99,646	4	24.00	Salary	32,354	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	93,988	7	18.00	Salary	19,912	21-7	4
5											5
6	Marvin Mermelstein	Administrative Asst	Administrative	See Above	149,468	7	25.00	Salary	48,532	17-7	6
7	Joseph Mermelstein	Owner	Administrative	50.00	78,886	3	25.00	Salary	25,614	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 190,229		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:

01/01/2008

Ending: 2/31/2008

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

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

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

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	Delivery Expense	Resident Beds	869	4	\$ 2,205	\$ 213	\$ 540	1	
2	21	Office Expenses	Resident Beds	869	4	4,269	213	1,046	2	
3	20	Dues & Subscription	Resident Beds	869	4	460	213	113	3	
4	21	Franchise Tax	Resident Beds	869	4	100	213	25	4	
5	22	Payroll Taxes	Resident Beds	869	4	131,039	213	32,119	5	
6	5	Utilities	Resident Beds	869	4	15,594	213	3,822	6	
7	26	Insurance	Resident Beds	869	4	1,745	213	428	7	
8	6	Repairs & Maintenance	Resident Beds	869	4	7,278	213	1,784	8	
9	22	Health Insurance	Resident Beds	869	4	12,490	213	3,061	9	
10	6	Scavenger	Resident Beds	869	4	538	213	132	10	
11	35	Equipment Rental	Resident Beds	869	4	1,777	213	436	11	
12	25	Auto Expense	Resident Beds	869	4	183	213	45	12	
13	21	Postage	Resident Beds	869	4	2,133	213	523	13	
14	19	Legal & Accounting	Resident Beds	869	4	24,000	213	5,883	14	
15	20	Licenses & Permits	Resident Beds	869	4	150	213	37	15	
16	30	Depreciation	Resident Beds	869	4	743	213	182	16	
17	21	Data Processing	Resident Beds	869	4	2,369	213	581	17	
18	21	Telephone	Resident Beds	869	4	7,780	213	1,907	18	
19	6	Plant Supervisor Salary	Direct Cost	1	1	32,354	32,354	1	32,354	19
20	17	Asst Administrator Salaries	Direct Cost	1	1	100,840	100,840	1	100,840	20
21	21	Office Manager Salary	Direct Cost	1	1	19,912	19,912	1	19,912	21
22	1	Food Service Supervisor Salary	Direct Cost	1	1	16,899	16,899	1	16,899	22
23	17	Administrative Salaries	Direct Cost	1	1	72,532	72,532	1	72,532	23
24	21	Administrator Salary	Direct Cost	1	1	119,937	119,937	1	119,937	24
25	TOTALS					\$ 577,327	\$ 362,474	\$ 415,138	25	

Facility Name & ID Number Balmoral Home

0039966 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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	17	Clerical Salaries	1	1	\$ 64,735	\$ 64,735	1	\$ 64,735	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				\$ 64,735	\$ 64,735		\$ 64,735	25

Facility Name & ID Number

Balmoral Home

0039966

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Parkway Bank & Trust		X	Line of Credit	Interest only	01/08	90,000		01/09	Variable	262									
7																				
8																				
9	TOTAL Facility Related						\$ 90,000	\$			\$ 262									
B. Non-Facility Related*																				
10																				
11																				
12																				
13	Interest Income										(262)									
14	TOTAL Non-Facility Related						\$	\$			\$ (262)									
15	TOTALS (line 9+line14)						\$ 90,000	\$			\$									

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 2007 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.)

\$ **235,657** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(14,343)** 3

4. Real Estate Tax accrual used for 2008 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.

\$ **235,657** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	248,707	8
	2004	254,232	9
	2005	256,820	10
	2006	238,200	11
	2007	235,657	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>235,657.00</u>	\$ <u>235,657.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>235,657.00</u>	\$ <u>235,657.00</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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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:

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

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$		\$	\$	\$ 985,048	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Leasehold Improvements		1994	8,500	218	39	218		3,279	9
10	Fence		1994	2,700	69	39	69		971	10
11	Leasehold Improvements		1995	4,813	123	39	123		1,627	11
12	Leasehold Improvements		1996	3,750		10			3,750	12
13	Fire Alarm		1996	8,750	225	39	225		2,906	13
14	Laundry Chute		1996	2,181	56	39	56		721	14
15	Concrete Ramp		1996	2,500	64	39	64		798	15
16	Phone System		1993	4,475		5			4,475	16
17	Time Clock System		1993	1,853		7			1,853	17
18	Carpet		1993	1,144		7			1,144	18
19	Phone System		1994	2,967		7			2,967	19
20	Hot Water System		1995	3,035		7			3,035	20
21	Awning and Signs		1996	5,923	151	39	151		1,829	21
22	Parking Lot		1997	6,600	271	20	330	59	4,290	22
23	Remodeling Laundry Area		1997	5,400	138	39	138		1,642	23
24	Remodeling Laundry Area		1997	19,779	508	39	508		5,980	24
25	Handrails		1997	5,750	148	39	148		1,700	25
26	Fire Alarm		1997	16,726	428	39	428		4,982	26
27	Light Fixtures		1997	6,552	39	39	39		5,498	27
28	Boiler		1997	925	24	39	24		271	28
29	Kitchen Improvements		1997	2,875	73	39	73		839	29
30	Elevator		1997	2,300	59	39	59		661	30
31	Bathroom Remodeling		1997	312	8	39	8		89	31
32	HVAC, Boiler		1998	14,915	383	39	383		4,030	32
33	Ward Doors		1998	2,803	72	39	72		740	33
34	Concrete Steps		1998	2,500	64	39	64		675	34
35	Fire Alarm		1998	16,000	410	39	410		3,948	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	39	\$ 475		\$ 4,723	37
38	Windows	1999	1,498	38	39	38		375	38
39	Cooling Tower	2000	8,860	227	39	227		1,978	39
40	Heater	2000	3,000	77	39	77		631	40
41	Vestibule Remodeling	2001	4,200	108	39	108		867	41
42	Elevator	2002	1,500	38	39	38		264	42
43	Carpet	2002	1,500	38	39	38		264	43
44	A/C Unit	2003	24,800	1,000	5	2,480	1,480	24,800	44
45	Elevator Hydraulic Power Unit	2006	14,000	359	39	359		748	45
46	Water Heater	2006	3,900	100	39	100		200	46
47	Wet Chem Suppression System	2006	2,225	57	39	57		114	47
48	Cooling Tower Slinger Assemble	2006	2,400	61	39	61		164	48
49	Motor Starter on Cooling Tower	2006	1,117	29	39	29		67	49
50	Pump Motor on Hot Water Heater	2006	1,406	36	39	36		105	50
51	Kitchen Exhaust Fan	2007	4,848	124	39	124		197	51
52	80 Ton Cooling Tower	2007	85,500	2,193	39	2,193		2,558	52
53	New Brick for Chimney	2007	5,500	141	39	141		165	53
54	Concrete Stairs	2007	6,500	167	39	167		181	54
55	Sump Pump	2007	3,600	90	39	90		154	55
56	Water Heater	2008	5,200	11	39	11		11	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)		\$ 1,341,130	\$ 8,900		\$ 10,439	\$ 1,539	\$ 1,088,314	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	\$ 36,576	\$ 4,093	\$ 5,225	\$ 1,132	5-7	\$ 31,422	71
72	Current Year Purchases	15,393	8,849	1,153	(7,696)	5-7	8,849	72
73	Fully Depreciated Assets	169,785	173	2,294	2,121	5-7	169,778	73
74	Management Company		182	721	539			74
75	TOTALS	\$ 221,754	\$ 13,297	\$ 9,393	\$ (3,904)		\$ 210,049	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	\$ 1,589	\$ 2,759	\$ 1,170	5	\$ 13,000	76
77										77
78										78
79										79
80	TOTALS			\$ 13,795	\$ 1,589	\$ 2,759	\$ 1,170		\$ 13,000	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)	\$ 1,667,109	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,786	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,591	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,195)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,311,363	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 3,228 Description: Copier - \$2,328; 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	\$ 5,331	17
18	Administrative	2008 Nissan Armada	570.00	3,751	18
19					19
20					20
21	TOTAL		\$ #####	\$ 9,082	21

10. Effective dates of current rental agreement:

Beginning 01/01/2008

Ending 12/31/2008

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

Fiscal Year Ending Annual Rent

12. /2009 \$ _____

13. /2010 \$ _____

14. /2011 \$ _____

* 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			215,794			215,794	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	Other (specify): _____									12
13	Other (specify): <u>Schedule Attached</u>					1,785	161		1,946	13
14	TOTAL			\$		\$ 217,579	\$ 161		\$ 217,740	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: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 570,163	\$ 570,163	1
2	Cash-Patient Deposits	46,408	46,408	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,800,152	1,800,152	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,898	70,898	6
7	Other Prepaid Expenses	18,251	18,251	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,505,872	\$ 2,505,872	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	309,006	309,006	15
16	Equipment, at Historical Cost	282,624	282,624	16
17	Accumulated Depreciation (book methods)	(326,315)	(1,311,363)	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)	\$ 265,315	\$ 355,745	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,771,187	\$ 2,861,617	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 139,938	\$ 139,938	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,844	49,844	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,532	73,532	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	11,800	11,800	35
Other Current Liabilities(specify):				
36	See Attached Schedule	1,181,024	1,181,024	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,706,138	\$ 1,706,138	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)	\$ 1,706,138	\$ 1,706,138	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,065,049	\$ 1,155,479	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,771,187	\$ 2,861,617	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 90,304	1
2	Restatements (describe):		2
3	Rounding	(13)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 90,291	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,039,558	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,064,800)	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)	\$ 974,758	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)	\$ 1,065,049	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	\$ 8,428,369	1
2	Discounts and Allowances for all Levels	(13,625)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,414,744	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,828	6
7	Oxygen	5,301	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 121,129	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	2,735	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,035	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,770	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	41,012	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 41,012	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Schedule Attached</u>	28,173	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 28,173	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,609,828	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,271,979	31
32	Health Care	2,223,771	32
33	General Administration	1,211,880	33
	B. Capital Expense		
34	Ownership	1,516,049	34
	C. Ancillary Expense		
35	Special Cost Centers	217,740	35
36	Provider Participation Fee	116,938	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,558,357	40
41	Income before Income Taxes (line 30 minus line 40)**	2,051,471	41
42	Income Taxes	(11,913)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,039,558	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:

01/01/2008

Ending:

12/31/2008

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	\$ 93,488	\$ 44.95	1
2	Assistant Director of Nursing	1,563	1,770	59,966	33.88	2
3	Registered Nurses	24,316	25,668	675,070	26.30	3
4	Licensed Practical Nurses	4,514	4,795	97,400	20.31	4
5	CNAs & Orderlies	70,746	74,088	696,711	9.40	5
6	CNA Trainees					6
7	Licensed Therapist	3,986	4,216	42,630	10.11	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,020	2,236	34,129	15.26	9
10	Activity Assistants	5,485	5,851	81,605	13.95	10
11	Social Service Workers	9,949	10,622	137,325	12.93	11
12	Dietician	624	624	7,173	11.50	12
13	Food Service Supervisor	1,201	1,313	17,780	13.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,313	24,199	233,121	9.63	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	14,302	15,670	150,683	9.62	18
19	Laundry	8,043	8,619	80,858	9.38	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,658	3,845	43,601	11.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,327	3,414	39,462	11.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	178,007	189,010	\$ 2,491,002 *	\$ 13.18	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	\$ 40,338	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	3,839	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	3,801	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 47,978		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 47,056	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ 47,056		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

