



Facility Name & ID Number Balmoral Home

# 0039966 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

**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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>67,982</u>	<u>654</u>	<u>4,699</u>	<u>73,335</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>67,982</u>	<u>654</u>	<u>4,699</u>	<u>73,335</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.33%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 10/10/1993

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 1993 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 34 and days of care provided 4,716

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	317,492	44,807	10,071	372,370		372,370	27,071	399,441		1
2	Food Purchase		351,012		351,012	(23,241)	327,771	(845)	326,926		2
3	Housekeeping	190,433	21,948		212,381		212,381		212,381		3
4	Laundry	95,114	13,716		108,830		108,830		108,830		4
5	Heat and Other Utilities			167,882	167,882		167,882	7,507	175,389		5
6	Maintenance			106,796	106,796		106,796	67,048	173,844		6
7	Other (specify):* <a href="#">Attached Schedule</a>			20,298	20,298		20,298	164	20,462		7
8	<b>TOTAL General Services</b>	603,039	431,483	305,047	1,339,569	(23,241)	1,316,328	100,945	1,417,273		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,773,779	240,366	54,232	2,068,377		2,068,377		2,068,377		10
10a	Therapy	64,809			64,809		64,809		64,809		10a
11	Activities	146,226	1,766		147,992		147,992		147,992		11
12	Social Services	169,100		3,930	173,030		173,030		173,030		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,153,914	242,132	58,162	2,454,208		2,454,208		2,454,208		16
	<b>C. General Administration</b>										
17	Administrative			826,546	826,546		826,546	(323,556)	502,990		17
18	Directors Fees										18
19	Professional Services			78,039	78,039		78,039	3,075	81,114		19
20	Dues, Fees, Subscriptions & Promotions			32,108	32,108		32,108	(19,082)	13,026		20
21	Clerical & General Office Expenses	52,896		60,353	113,249		113,249	96,431	209,680		21
22	Employee Benefits & Payroll Taxes			501,425	501,425	23,241	524,666	63,606	588,272		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,626	1,626		1,626		1,626		24
25	Other Admin. Staff Transportation			4,082	4,082		4,082	(368)	3,714		25
26	Insurance-Prop.Liab.Malpractice			176,783	176,783		176,783	1,462	178,245		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	52,896		1,680,962	1,733,858	23,241	1,757,099	(178,432)	1,578,667		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,809,849	673,615	2,044,171	5,527,635		5,527,635	(77,487)	5,450,148		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 &amp; ID Number

Balmoral Home

#0039966

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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	
	<b>D. Ownership</b>											
30	Depreciation			13,819	13,819		13,819	6,773	20,592			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			225	225		225	(225)				32
33	Real Estate Taxes							221,869	221,869			33
34	Rent-Facility & Grounds			2,011,559	2,011,559		2,011,559	(2,011,559)				34
35	Rent-Equipment & Vehicles			8,783	8,783		8,783	20	8,803			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,034,386	2,034,386		2,034,386	(1,783,122)	251,264			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,898	336,925	338,823		338,823		338,823			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			533,342	533,342		533,342		533,342			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,898	870,267	872,165		872,165		872,165			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,809,849	675,513	4,948,824	8,434,186		8,434,186	(1,860,609)	6,573,577			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(1,913)	30		9
10	Interest and Other Investment Income	(231)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(845)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(612)	25		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(200)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,210)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,061)	21		24
25	Fund Raising, Advertising and Promotional	(22,356)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(572)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (61,000)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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	(1,799,609)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,799,609)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,860,609)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

**BHF USE ONLY**

48		49		50		51		52
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Balmoral Home

ID# 0039966

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Franchise Tax	\$ (238)	21	1
2	Trust Fees	(75)	21	2
3	Contributions (Management Company)	(3)	21	3
4	Sales Tax (Management Company)	(256)	2	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	<b>Total</b>	(572)		49

## STATE OF ILLINOIS

Summary A

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

01/01/2013

Ending: 12/31/2013

## 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	27,071	0	0	0	0	0	0	0	0	27,071	1
2	Food Purchase	(1,101)	0	256	0	0	0	0	0	0	0	0	(845)	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	7,507	0	0	0	0	0	0	0	0	0	7,507	5
6	Maintenance	0	1,509	65,539	0	0	0	0	0	0	0	0	67,048	6
7	Other (specify):*	0	164	0	0	0	0	0	0	0	0	0	164	7
8	<b>TOTAL General Services</b>	<b>(1,101)</b>	<b>9,180</b>	<b>92,866</b>	<b>0</b>	<b>100,945</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(323,556)	0	0	0	0	0	0	0	0	(323,556)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,210)	0	4,285	0	0	0	0	0	0	0	0	3,075	19
20	Fees, Subscriptions & Promotions	(22,356)	3,025	249	0	0	0	0	0	0	0	0	(19,082)	20
21	Clerical & General Office Expenses	(33,577)	4,150	125,858	0	0	0	0	0	0	0	0	96,431	21
22	Employee Benefits & Payroll Taxes	0	63,606	0	0	0	0	0	0	0	0	0	63,606	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	(612)	43	201	0	0	0	0	0	0	0	0	(368)	25
26	Insurance-Prop.Liab.Malpractice	0	1,462	0	0	0	0	0	0	0	0	0	1,462	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(57,755)</b>	<b>72,286</b>	<b>(192,963)</b>	<b>0</b>	<b>(178,432)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(58,856)</b>	<b>81,466</b>	<b>(100,097)</b>	<b>0</b>	<b>(77,487)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Balmoral Home

# 0039966

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	(1,913)	0	8,686	0	0	0	0	0	0	0	0	6,773	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(231)	6	0	0	0	0	0	0	0	0	0	(225)	32
33	Real Estate Taxes	0	0	221,869	0	0	0	0	0	0	0	0	221,869	33
34	Rent-Facility & Grounds	0	20,481	(2,032,040)	0	0	0	0	0	0	0	0	(2,011,559)	34
35	Rent-Equipment & Vehicles	0	0	20	0	0	0	0	0	0	0	0	20	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,144)</b>	<b>20,487</b>	<b>(1,801,465)</b>	<b>0</b>	<b>(1,783,122)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(61,000)</b>	<b>101,953</b>	<b>(1,901,562)</b>	<b>0</b>	<b>(1,860,609)</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	25 Auto Expense	\$	Nivram Management, Inc.	50.00%	\$ 43	\$	43	1
2	V	6 Repairs & Maintenance		Nivram Management, Inc.	50.00%	1,509		1,509	2
3	V	5 Utilities		Nivram Management, Inc.	50.00%	7,507		7,507	3
4	V	21 Contributions		Nivram Management, Inc.	50.00%	3		3	4
5	V	21 Office Expense		Nivram Management, Inc.	50.00%	4,103		4,103	5
6	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	3,025		3,025	6
7	V	21 Taxes - Other		Nivram Management, Inc.	50.00%	44		44	7
8	V	32 Interest Expense		Nivram Management, Inc.	50.00%	6		6	8
9	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	47,316		47,316	9
10	V	34 Rent		Nivram Management, Inc.	50.00%	20,481		20,481	10
11	V	26 Insurance		Nivram Management, Inc.	50.00%	1,462		1,462	11
12	V	22 Health Insurance		Nivram Management, Inc.	50.00%	16,290		16,290	12
13	V	7 Scavenger		Nivram Management, Inc.	50.00%	164		164	13
14	Total		\$			\$ 101,953	\$ *	101,953	14

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

Facility Name &amp; ID Number

Balmoral Home

# 0039966

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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	35 Rental Equipment	\$	Nivram Management, Inc.	50.00%	\$ 20	\$	20	15
16	V	2 Sales Taxes		Nivram Management, Inc.	50.00%	256		256	16
17	V	21 Postage		Nivram Management, Inc.	50.00%	697		697	17
18	V	19 Legal & Accounting		Nivram Management, Inc.	50.00%	1,335		1,335	18
19	V	20 Licenses & Permits		Nivram Management, Inc.	50.00%	249		249	19
20	V	25 Travel		Nivram Management, Inc.	50.00%	201		201	20
21	V	30 Depreciation		Nivram Management, Inc.	50.00%	1,168		1,168	21
22	V	21 Data Processing		Nivram Management, Inc.	50.00%	984		984	22
23	V	6 Plant Supervisor Salary		Nivram Management, Inc.	50.00%	65,539		65,539	23
24	V	17 Asst. Administrator Salary		Nivram Management, Inc.	50.00%	163,309		163,309	24
25	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	40,756		40,756	25
26	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	27,071		27,071	26
27	V	17 Administrative Salaries		Nivram Management, Inc.	50.00%	108,934		108,934	27
28	V	17 Administrator Salary		Nivram Management, Inc.	50.00%	230,747		230,747	28
29	V	21 Clerical Salaries		Nivram Management, Inc.	50.00%	83,326		83,326	29
30	V	17 Management Fees	826,546	Nivram Management, Inc.	50.00%			(826,546)	30
31	V	34 Rental Income	20,481	Hamlin Arthur Building Partnership				(20,481)	31
32	V	21 Bank Fees		Hamlin Arthur Building Partnership		95		95	32
33	V	30 Depreciation		Hamlin Arthur Building Partnership		7,518		7,518	33
34	V	19 Legal Fees		Hamlin Arthur Building Partnership		2,950		2,950	34
35	V	33 Real Estate Taxes		Hamlin Arthur Building Partnership		10,310		10,310	35
36	V	33 Real Estate Taxes				211,559		211,559	36
37	V	34 Rental Income	2,011,559					(2,011,559)	37
38	V								38
39	Total		\$ 2,858,586			\$ 957,024	\$ *	(1,901,562)	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	<b>Total</b>		\$			\$	0	\$ *	39

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



Facility Name &amp; ID Number

Balmoral Home

#

0039966

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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	166,667	13	33.33	Salary	\$ 83,333	17-7	1
2	Louise Mermelstein	Food Serv Superv	Support	0.00	54,142	6	33.33	Salary	27,071	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	126,463	6	34.13	Salary	65,539	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	81,512	13	33.33	Salary	40,756	21-7	4
5											5
6	Marvin Mermelstein	Administrative Asst.	Administrative	See Above	189,695	9	34.13	Salary	98,309	17-7	6
7	Joseph Mermelstein	Owner	Administrative	50.00	49,399	4	34.13	Salary	25,601	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 340,609		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: 01/01/2013 Ending: 2/31/2013

## VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto Expense	Resident Beds	624	3	\$ 126	213	\$ 43	1
2	6	Repair & Maintenance	Resident Beds	624	3	4,422	213	1,509	2
3	5	Utilities	Resident Beds	624	3	21,992	213	7,507	3
4	21	Contributions	Resident Beds	624	3	10	213	3	4
5	21	Office Expense	Resident Beds	624	3	12,020	213	4,103	5
6	20	Dues & Subscriptions	Resident Beds	624	3	8,861	213	3,025	6
7	21	Taxes Other	Resident Beds	624	3	128	213	44	7
8	32	Interest Expense	Resident Beds	624	3	19	213	6	8
9	22	Payroll Taxes	Resident Beds	624	3	138,615	213	47,316	9
10	34	Rent	Resident Beds	624	3	60,000	213	20,481	10
11	26	Insurance	Resident Beds	624	3	4,282	213	1,462	11
12	22	Health Insurance	Resident Beds	624	3	47,724	213	16,290	12
13	7	Scavenger	Resident Beds	624	3	480	213	164	13
14	35	Rental Equipment	Resident Beds	624	3	60	213	20	14
15	2	Sales Taxes	Resident Beds	624	3	749	213	256	15
16	21	Postage	Resident Beds	624	3	2,042	213	697	16
17	19	Legal & Accounting	Resident Beds	624	3	3,911	213	1,335	17
18	20	Licenses & Permits	Resident Beds	624	3	729	213	249	18
19	25	Travel	Resident Beds	624	3	590	213	201	19
20	30	Depreciation	Resident Beds	624	3	3,422	213	1,168	20
21	21	Data Processing	Resident Beds	624	3	2,884	213	984	21
22	6	Plant Supervisor Salary	Resident Beds	1	1	65,539	65,539	65,539	22
23	17	Asst. Administrator Salary	Resident Beds	1	1	163,309	163,309	163,309	23
24	21	Office Manager Salary	Resident Beds	1	1	40,756	40,756	40,756	24
25	TOTALS					\$ 582,670	\$ 269,604	\$ 376,467	25

Facility Name & ID Number Balmoral Home

# 0039966

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Food Service Supervisor Salary	Direct Cost	1	\$ 27,071	\$ 27,071	1	\$ 27,071	1
2	17	Administrative Salaries	Direct Cost	1	108,934	108,934	1	108,934	2
3	17	Administrator Salary	Direct Cost	1	230,747	230,747	1	230,747	3
4	21	Clerical Salary	Direct Cost	1	83,326	83,326	1	83,326	4
5	21	Bank Fees	Resident Beds	624	279		213	95	5
6	30	Depreciation Expense	Resident Beds	624	22,025		213	7,518	6
7	19	Legal Fees	Resident Beds	624	8,643		213	2,950	7
8	33	Real Estate Taxes	Resident Beds	624	30,203		213	10,310	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				\$ 511,228	\$ 450,078		\$ 470,951	25

Facility Name & ID Number

Balmoral Home

# 0039966

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	Parkway Bank & Trust		X	Line of Credit	Int Only	12/28/12	177,330		6/28/13	0.0325	225	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 177,330	\$			\$ 225	9						
<b>B. Non-Facility Related*</b>																		
10	Credit Card		X	Financing	n/a	n/a	n/a	n/a	n/a	n/a	6	10						
11	Offset Interest Income										(231)	11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (225)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 177,330	\$			\$	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.			\$ <b>250,000</b>	<b>1</b>	
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.)			\$ <b>221,869</b>	<b>2</b>	
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>(28,131)</b>	<b>3</b>	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>250,000</b>	<b>4</b>	
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>5</b>	
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<b>6</b>	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>221,869</b>	<b>7</b>	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	<b>2008</b>	<b>238,021</b>	<b>8</b>		
	<b>2009</b>	<b>272,770</b>	<b>9</b>		
	<b>2010</b>	<b>284,645</b>	<b>10</b>		
	<b>2011</b>	<b>261,570</b>	<b>11</b>		
	<b>2012</b>	<b>246,679</b>	<b>12</b>		
				<b>FOR BHF USE ONLY</b>	
				<b>13</b>	<b>13</b>
				<b>14</b>	<b>14</b>
				<b>15</b>	<b>15</b>
				<b>16</b>	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

**2012 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 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-07-109-036-0000</u>	<u>Nursing Home</u>	\$ <u>211,559.00</u>	\$ <u>211,559.00</u>
2. <u>14-35-325-029-0000</u>	<u>Management Co. Building</u>	\$ <u>4,022.75</u>	\$ <u>1,180.91</u>
3. <u>14-35-325-015-0000</u>	<u>Management Co. Building</u>	\$ <u>31,097.53</u>	\$ <u>9,128.92</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>246,679.28</u></u>	\$ <u><u>221,868.83</u></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? X YES        NO

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

**C. Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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:

01/01/2013 Ending:

12/31/2013

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).

N/A

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Nursing Home, 33,375, 1993, \$90,430, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 33,375, (blank), \$90,430, 3.

Facility Name &amp; ID Number Balmoral Home

# 0039966

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	213	1993	1968	\$ 985,048	\$		\$	\$	\$ 985,048	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Leasehold Improvements	1994		8,500	218	39	218		4,369	9
10	Fence	1994		2,700	69	39	69		1,316	10
11	Leasehold Improvements	1995		4,813	124	39	124		2,247	11
12	Leasehold Improvements	1996		3,750		10			3,750	12
13	Fire Alarm	1996		8,750	224	39	224		4,026	13
14	Laundry Chute	1996		2,181	56	39	56		1,001	14
15	Concrete Ramp	1996		2,500	64	39	64		1,118	15
16	Phone System	1993		4,475		5			4,475	16
17	Time Clock System	1993		1,853		7			1,853	17
18	Carpet	1993		1,144		7			1,144	18
19	Phone System	1994		2,967		7			2,967	19
20	Hot Water System	1995		3,035		7			3,035	20
21	Awning and Sign	1996		5,923	152	39	152		2,589	21
22	Parking Lot	1997		6,600	272	20	272		5,824	22
23	Remodeling Laundry Area	1997		5,400	139	39	139		2,337	23
24	Remodeling Laundry Area	1997		19,779	507	39	507		8,515	24
25	Handrails	1997		5,750	147	39	147		2,435	25
26	Fire Alarm	1997		16,726	429	39	429		7,127	26
27	Light Fixtures	1997		6,552	38	39	38		5,688	27
28	Boiler	1997		925	24	39	24		391	28
29	Kitchen Improvements	1997		2,875	74	39	74		1,209	29
30	Elevator	1997		2,300	59	39	59		956	30
31	Bathroom Remodeling	1997		312	8	39	8		129	31
32	HVAC, Boiler	1997		14,915	382	39	382		5,940	32
33	Ward Doors	1998		2,803	72	39	72		1,100	33
34	Concrete Steps	1998		2,500	64	39	64		995	34
35	Fire Alarm	1998		16,000	410	39	410		5,998	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Balmoral Home

# 0039966

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Boiler and Duckwork	1999	\$ 18,500	\$ 474	39	\$ 474	\$	\$ 6,666	37
38	Windows	1999	1,498	39	39	39		570	38
39	Cooling Tower	2000	8,860	227	39	227		3,113	39
40	Heater	2000	3,000	77	39	77		1,016	40
41	Vestibule Remodeling	2001	4,200	108	39	108		1,407	41
42	Elevator	2002	1,500	39	39	39		459	42
43	Carpet	2002	1,500	39	39	39		459	43
44	A/C Unit	2003	24,800		5			24,800	44
45	Elevator Hydraulic Power Unit	2006	14,000	359	39	359		2,543	45
46	Water Heater	2006	3,900	100	39	100		700	46
47	Wet Che Supression System	2006	2,225	57	39	57		399	47
48	Cooling Tower Slinger Assemble	2006	2,400	62	39	62		474	48
49	Motor Starter on Cooling Tower	2006	1,117	28	39	28		207	49
50	Pump Motor on Hot Water Heater	2006	1,406	36	39	36		285	50
51	Kitchen Exhaust Fan	2007	4,848	124	39	124		817	51
52	80 Ton Cooling Tower	2007	85,500	2,192	39	2,192		13,518	52
53	New Brick for Chimney	2007	5,500	141	39	141		870	53
54	Concret Stairs	2007	6,500	166	39	166		1,011	54
55	Sump Pump	2007	3,600	90	39	90		604	55
56	Water Heater	2008	5,200	133	39	133		676	56
57	Valves	2010	4,500	115	39	115		432	57
58	Sprinkler System Heads & Valves	2011	3,330	86	39	86		186	58
59	Elevator Project	2012	20,912	536	39	536		984	59
60	Pump	2012	2,500	64	39	64		42	60
61	Fire Dampers in Ducts	2012	5,000	129	39	129		106	61
62	Door Project	2012	58,002	1,487	39	1,487		496	62
63	Water Pump	2012	3,017	77	39	77		52	63
64	Heating System	2013	51,200	656	39	656		656	64
65	Water Heater	2013	6,599	127	39	127		127	65
66	Water Heater	2013	10,800	46	39	46		46	66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,506,990	\$ 11,346		\$ 11,346	\$	\$ 1,131,303	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 25,666	\$ 794	\$	\$ (794)	5-7	\$ 25,666	71
72	Current Year Purchases	2,798	1,679	560	(1,119)	5	560	72
73	Fully Depreciated Assets	198,256					198,256	73
74	Mng Company and RE Prt		8,686	8,686				74
75	TOTALS	\$ 226,720	\$ 11,159	\$ 9,246	\$ (1,913)		\$ 224,482	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,824,140	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,505	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,592	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,913)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,355,785	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: 01/01/2013

Ending: 12/31/2013

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: Annual Lease \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 2,695 Description: Copier - \$1,703; Ice Maker - \$972; Management Company - Copier - \$20

(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	<u>Administrative</u>	<u>2012 Subaru Outback</u>	\$ <u>509.00</u>	\$ <u>6,108</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>509.00</u>	\$ <u>6,108</u>	21

10. Effective dates of current rental agreement:

Beginning 01/01/2013

Ending 12/31/2013

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

Fiscal Year Ending Annual Rent

12. /2014 \$ \_\_\_\_\_

13. /2015 \$ \_\_\_\_\_

14. /2016 \$ \_\_\_\_\_

\* 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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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			336,925			336,925	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): <u>Respiratory</u>						1,898		1,898	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 336,925	\$ 1,898		\$ 338,823	14

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

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 646,858	\$ 646,858	1
2	Cash-Patient Deposits	41,447	41,447	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,543,578	1,543,578	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	120,465	120,465	6
7	Other Prepaid Expenses	32,721	32,721	7
8	Accounts Receivable (owners or related parties)	17,141	17,141	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,402,210	\$ 2,402,210	10
	<b>B. Long-Term Assets</b>			
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	474,866	474,866	15
16	Equipment, at Historical Cost	273,795	273,795	16
17	Accumulated Depreciation (book methods)	(372,314)	(1,357,362)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 376,347	\$ 466,777	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,778,557	\$ 2,868,987	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 177,601	\$ 177,601	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,453	41,453	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,599	123,599	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,747	16,747	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Attached Schedule</u>	2,107,861	2,107,861	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,717,261	\$ 2,717,261	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,717,261	\$ 2,717,261	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 61,296	\$ 151,726	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,778,557	\$ 2,868,987	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>578,812</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>(1)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>578,811</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,290,541</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(1,808,056)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(517,515)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>61,296</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Balmoral Home

# 0039966

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,572,899	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,572,899	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	136,835	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 136,835	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Attached Schedule</u>	31,992	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 31,992	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,741,726	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	8,434,186	31
32	Health Care		32
33	General Administration		33
<b>B. Capital Expense</b>			
34	Ownership		34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,434,186	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,307,540	41
42	<b>Income Taxes</b>	(16,999)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,290,541	43

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

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

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

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

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

Facility Name & ID Number Balmoral Home

# 0039966

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,256	\$ 93,969	\$ 41.65	1
2	Assistant Director of Nursing	1,891	2,119	74,283	35.06	2
3	Registered Nurses	22,784	24,255	658,485	27.15	3
4	Licensed Practical Nurses	4,418	4,730	106,196	22.45	4
5	CNAs & Orderlies	76,104	80,499	796,046	9.89	5
6	CNA Trainees					6
7	Licensed Therapist	3,994	4,370	64,809	14.83	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,880	2,096	37,240	17.77	9
10	Activity Assistants	8,092	8,579	108,986	12.70	10
11	Social Service Workers	9,720	10,088	169,100	16.76	11
12	Dietician					12
13	Food Service Supervisor	2,112	2,368	51,304	21.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,097	24,447	266,188	10.89	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	16,872	18,305	190,433	10.40	18
19	Laundry	7,770	8,530	95,114	11.15	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,051	3,317	52,896	15.95	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					31
32	Other Health Care: <u>Med Records</u>	3,958	4,230	44,800	10.59	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	186,823	200,189	\$ 2,809,849 *	\$ 14.04	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	\$ 10,071	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	676	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	3,930	12-3	45
46	Other(specify) <u>Psycho Social</u>	S	460	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 15,137		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,329	\$ 53,096	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,329	\$ 53,096		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	\$ 71,644	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	21,645	Advertising: Employee Recruitment	929	
				FICA Taxes	211,717	Health Care Worker Background Check (Indicate # of checks performed )		
				Employee Health Insurance	182,260	Patient Background Checks	94	
				Employee Meals	23,241	Advertising and Promotions	22,356	
				Illinois Municipal Retirement Fund (IMRF)*		Attached Schedule	3,903	
				Employee Benefits	13,349	Allocation from Management Company	3,274	
				Chicago Head Tax	810			
				Allocation from Management Company	63,606			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	(22,356)	
Description			Amount			Yellow page advertising	( )	
Management Fees			\$ 826,546			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,026	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 588,272			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 826,546	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
Attached Schedule			78,039					
							In-State Travel	
							Seminar Expense	1,626
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 78,039	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,626

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Balmoral Home# 0039966Report Period Beginning: 01/01/2013Ending: 12/31/2013**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ No Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 533,342  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 23,241 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. **Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees