FOR BHF USE

LL1

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0039966

Facility Name: Balmoral Home

Address: 2055 W Balmoral Ave (Number) Chicago (City) 60625 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Sanford B. Alper, Director
(Firm Name & Address) Kessler, Orlean, Silver & Company, P.C., 1101 Lake Cook Road, Suite C, Deerfield IL 60015
(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	213	Skilled (SNF)	213	77,745	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	213	TOTALS	213	77,745	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	64,882	1,542	5,718	72,142	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,882	1,542	5,718	72,142	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.79%

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 4,873

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	322,379	30,221	10,930	363,530		363,530	25,266	388,796			1
2	Food Purchase		360,497		360,497	(27,964)	332,533	(2,646)	329,887			2
3	Housekeeping	205,354	35,941		241,295		241,295		241,295			3
4	Laundry	96,991	8,181		105,172		105,172		105,172			4
5	Heat and Other Utilities			206,750	206,750		206,750	8,871	215,621			5
6	Maintenance		102,514		102,514		102,514	143,085	245,599			6
7	Other (specify):* Attached Schedule			22,570	22,570		22,570	673	23,243			7
8	TOTAL General Services	624,724	537,354	240,250	1,402,328	(27,964)	1,374,364	175,249	1,549,613			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,713,776	237,688	128,980	2,080,444		2,080,444		2,080,444			10
10a	Therapy	64,876		1,728	66,604		66,604		66,604			10a
11	Activities	152,473	2,779		155,252		155,252		155,252			11
12	Social Services	212,121		550	212,671		212,671		212,671			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,143,246	240,467	131,258	2,514,971		2,514,971		2,514,971			16
	C. General Administration											
17	Administrative			1,178,618	1,178,618		1,178,618	(425,562)	753,056			17
18	Directors Fees											18
19	Professional Services			83,343	83,343		83,343	278	83,621			19
20	Dues, Fees, Subscriptions & Promotions			42,336	42,336		42,336	(31,782)	10,554			20
21	Clerical & General Office Expenses	26,792		152,741	179,533		179,533	20,579	200,112			21
22	Employee Benefits & Payroll Taxes			532,212	532,212	27,964	560,176	75,773	635,949			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,960	1,960		1,960		1,960			24
25	Other Admin. Staff Transportation			1,686	1,686		1,686	411	2,097			25
26	Insurance-Prop.Liab.Malpractice			189,565	189,565		189,565	2,079	191,644			26
27	Other (specify):*											27
28	TOTAL General Administration	26,792		2,182,461	2,209,253	27,964	2,237,217	(358,224)	1,878,993			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,794,762	777,821	2,553,969	6,126,552		6,126,552	(182,975)	5,943,577			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: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			60,686	60,686		60,686	15,840	76,526			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							227,398	227,398			33
34	Rent-Facility & Grounds			2,014,422	2,014,422		2,014,422	(2,014,422)				34
35	Rent-Equipment & Vehicles			8,251	8,251		8,251	85	8,336			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,083,359	2,083,359		2,083,359	(1,771,099)	312,260			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,609	407,227	409,836		409,836		409,836			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			525,652	525,652		525,652		525,652			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		2,609	932,879	935,488		935,488		935,488			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,794,762	780,430	5,570,207	9,145,399		9,145,399	(1,954,074)	7,191,325			45

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	272	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	(776)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(253)	25		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(123,447)	21		24
25	Fund Raising, Advertising and Promotional	(34,609)	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 See Attached Schedule	(2,042)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (160,855)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,793,219)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,793,219)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,954,074)		37

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

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

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

Balmoral Home

ID# 0039966

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Franchise Tax	$ (100)	21	1
2	Trust Fees	(75)	21	2
3	Sales Taxes (Management Company)	(1,870)	2	3
4	Interest Income in Excess of Interest Expense	3	32	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	**Total**	(2,042)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	25,266	0	0	0	0	0	0	0	0	25,266	1
2	Food Purchase	(2,646)	0	0	0	0	0	0	0	0	0	0	(2,646)	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	8,871	0	0	0	0	0	0	0	0	0	8,871	5
6	Maintenance	0	841	142,244	0	0	0	0	0	0	0	0	143,085	6
7	Other (specify):*	0	673	0	0	0	0	0	0	0	0	0	673	7
8	**TOTAL General Services**	(2,646)	10,385	167,510	0	0	0	0	0	0	0	0	175,249	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	(425,562)	0	0	0	0	0	0	0	0	(425,562)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	278	0	0	0	0	0	0	0	0	278	19
20	Fees, Subscriptions & Promotions	(34,609)	2,672	155	0	0	0	0	0	0	0	0	(31,782)	20
21	Clerical & General Office Expenses	(123,622)	4,333	139,868	0	0	0	0	0	0	0	0	20,579	21
22	Employee Benefits & Payroll Taxes	0	75,270	503	0	0	0	0	0	0	0	0	75,773	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	(253)	617	47	0	0	0	0	0	0	0	0	411	25
26	Insurance-Prop.Liab.Malpractice	0	2,079	0	0	0	0	0	0	0	0	0	2,079	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(158,484)	84,971	(284,711)	0	0	0	0	0	0	0	0	(358,224)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(161,130)	95,356	(117,201)	0	0	0	0	0	0	0	0	(182,975)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Balmoral Home # 0039966 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	272	0	15,568	0	0	0	0	0	0	0	0	15,840	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	3	0	(3)	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	227,398	0	0	0	0	0	0	0	0	227,398	33
34	Rent-Facility & Grounds	0	20,481	(2,034,903)	0	0	0	0	0	0	0	0	(2,014,422)	34
35	Rent-Equipment & Vehicles	0	85	0	0	0	0	0	0	0	0	0	85	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	275	20,566	(1,791,940)	0	0	0	0	0	0	0	0	(1,771,099)	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)**	(160,855)	115,922	(1,909,141)	0	0	0	0	0	0	0	0	(1,954,074)	45

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Mermelstein Trust	50.00	Chicago Ridge Nursing & Rehab Center	Chicago Ridge			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	25	Auto Expense	$	Nivram Management, Inc.	100.00%	$ 617	$ 617	1
2	V	6	Repair & Maintenance		Nivram Management, Inc.	100.00%	841	841	2
3	V	5	Utilities		Nivram Management, Inc.	100.00%	8,871	8,871	3
4	V	21	Office Expense		Nivram Management, Inc.	100.00%	4,290	4,290	4
5	V	20	Dues & Subscriptions		Nivram Management, Inc.	100.00%	2,603	2,603	5
6	V	21	Taxes - Other		Nivram Management, Inc.	100.00%	43	43	6
7	V	22	Payroll Taxes		Nivram Management, Inc.	100.00%	58,305	58,305	7
8	V	34	Rent Expense		Nivram Management, Inc.	100.00%	20,481	20,481	8
9	V	26	Insurance Expense		Nivram Management, Inc.	100.00%	2,079	2,079	9
10	V	20	Advertising		Nivram Management, Inc.	100.00%	69	69	10
11	V	22	Health Insurance		Nivram Management, Inc.	100.00%	16,965	16,965	11
12	V	7	Scavenger		Nivram Management, Inc.	100.00%	673	673	12
13	V	35	Rental Equipment		Nivram Management, Inc.	100.00%	85	85	13
14	Total			$			$ 115,922	$ * 115,922	14

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Postage	$	Nivram Management, Inc.	100.00%	$ 810	$ 810	15
16	V	19	Professional Fees		Nivram Management, Inc.	100.00%	278	278	16
17	V	20	Licenses & Permits		Nivram Management, Inc.	100.00%	155	155	17
18	V	25	Travel		Nivram Management, Inc.	100.00%	47	47	18
19	V	30	Depreciation		Nivram Management, Inc.	100.00%	1,374	1,374	19
20	V	21	Data Processing		Nivram Management, Inc.	100.00%	1,380	1,380	20
21	V	6	Sales Taxes		Nivram Management, Inc.	100.00%	1,870	1,870	21
22	V	22	Employee Wealfare		Nivram Management, Inc.	100.00%	503	503	22
23	V	6	Plant Supervisor Salary		Nivram Management, Inc.	100.00%	140,374	140,374	23
24	V	17	Asst. Administrator Salary		Nivram Management, Inc.	100.00%	285,109	285,109	24
25	V	21	Office Manager Salary		Nivram Management, Inc.	100.00%	40,825	40,825	25
26	V	1	Food Service Supervisor Salary		Nivram Management, Inc.	100.00%	25,266	25,266	26
27	V	17	Administrative Salaries		Nivram Management, Inc.	100.00%	108,934	108,934	27
28	V	17	Administrator Salary		Nivram Management, Inc.	100.00%	359,013	359,013	28
29	V	21	Clerical Salaries		Nivram Management, Inc.	100.00%	96,758	96,758	29
30	V	17	Management Fees	1,178,618	Nivram Management, Inc.	100.00%		(1,178,618)	30
31	V	34	Rental Income	20,481	Hamlin Arthur Building Partnership	100.00%		(20,481)	31
32	V	32	Interest Income	3	Hamlin Arthur Building Partnership	100.00%		(3)	32
33	V	21	Bank Fees		Hamlin Arthur Building Partnership	100.00%	95	95	33
34	V	30	Depreciation		Hamlin Arthur Building Partnership	100.00%	14,194	14,194	34
35	V	33	Real Estate Taxes		Hamlin Arthur Building Partnership	100.00%	12,976	12,976	35
36	V	34	Rental Income	2,014,422		100.00%		(2,014,422)	36
37	V	33	Real Estate Taxes			100.00%	214,422	214,422	37
38	V								38
39	Total			$ 3,213,524			$ 1,304,383	$ * (1,909,141)	39

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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	50,533	6	33.33	Salary	25,266	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	270,862	6	34.13	Salary	140,374	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	81,651	13	33.33	Salary	40,825	21-7	4
5											5
6	Marvin Mermelstein	Administrative Asst.	Administrative	See Above	406,294	9	34.13	Salary	210,561	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	$ 525,960		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: 01/01/2014 Ending: 2/31/2014

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 [X] 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	25	Auto Expense	Resident Beds	624	3	$ 1,807	$	213	$ 617	1
2	6	Repair & Maintenance	Resident Beds	624	3	2,463		213	841	2
3	5	Utilities	Resident Beds	624	3	25,987		213	8,871	3
4	21	Office Expense	Resident Beds	624	3	12,567		213	4,290	4
5	20	Dues & Subscriptions	Resident Beds	624	3	7,626		213	2,603	5
6	21	Taxes - Other	Resident Beds	624	3	126		213	43	6
7	22	Payroll Taxes	Resident Beds	624	3	170,810		213	58,305	7
8	34	Rent Expense	Resident Beds	624	3	60,000		213	20,481	8
9	26	Insurance Expense	Resident Beds	624	3	6,092		213	2,079	9
10	20	Advertising	Resident Beds	624	3	202		213	69	10
11	22	Health Insurance	Resident Beds	624	3	49,699		213	16,965	11
12	7	Scavenger	Resident Beds	624	3	1,972		213	673	12
13	35	Rental Equipment	Resident Beds	624	3	250		213	85	13
14	21	Postage	Resident Beds	624	3	2,373		213	810	14
15	19	Professional Fees	Resident Beds	624	3	813		213	278	15
16	20	Licenses & Permits	Resident Beds	624	3	455		213	155	16
17	25	Travel	Resident Beds	624	3	138		213	47	17
18	30	Depreciation	Resident Beds	624	3	4,024		213	1,374	18
19	21	Data Processing	Resident Beds	624	3	4,044		213	1,380	19
20	6	Sales Taxes	Resident Beds	624	3	5,479		213	1,870	20
21	22	Employee Wealfare	Resident Beds	624	3	1,473		213	503	21
22	6	Plant Supervisor Salary	Director Cost	1	1	140,374	140,374	1	140,374	22
23	17	Asst. Administrator Salary	Director Cost	1	1	285,109	285,109	1	285,109	23
24	21	Office Manager Salary	Director Cost	1	1	40,825	40,825	1	40,825	24
25	TOTALS					$ 824,708	$ 466,308		$ 588,647	25

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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 [X] NO [ ]

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

Name of Related Organization: Nivram Manager, 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	1	Food Service Supervisor Salary	Direct Cost	1	1	$ 25,266	$ 25,266	1	$ 25,266	1
2	17	Administrative Salaries	Direct Cost	1	1	108,934	108,934	1	108,934	2
3	17	Administrator Salary	Direct Cost	1	1	359,013	359,013	1	359,013	3
4	21	Clerical Salaries	Direct Cost	1	1	96,758	96,758	1	96,758	4
5	21	Bank Fees	Direct Cost	624	3	280		213	96	5
6	30	Depreciation	Direct Cost	624	3	41,584		213	14,195	6
7	33	Real Estate Taxes	Direct Cost	624	3	38,014		213	12,976	7
8	33	Real Estate Taxes								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					$ 669,849	$ 589,971		$ 617,238	25

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

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

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)	$	227,398	2
3. Under or (over) accrual (line 2 minus line 1).	$	(22,602)	3
4. Real Estate Tax accrual used for 2014 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.	$	227,398	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	272,770	8
2010	284,645	9
2011	261,570	10
2012	246,679	11
2013	214,422	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-07-109-036-0000	Nursing Home	$ 214,421.84	$ 214,421.84
2.	14-35-325-029-0000	Management Co. Building	$ 4,151.28	$ 1,219.00
3.	14-35-325-015-0000	Management Co. Building	$ 40,050.85	$ 11,757.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 258,623.97	$ 227,397.84

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	2,136	39	2,136		6,505	9
10	Fence			1994	2,700	649	39	649		1,965	10
11	Leasehold Improvements			1995	4,813	1,113	39	1,113		3,360	11
12	Leasehold Improvements			1996	3,750		10			3,750	12
13	Fire Alarm			1996	8,750	2,003	39	2,003		6,029	13
14	Laundry Chute			1996	2,181	497	39	497		1,498	14
15	Concrete Ramp			1996	2,500	559	39	559		1,677	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	1,298	39	1,298		3,887	21
22	Parking Lot			1997	6,600		20	272	272	6,096	22
23	Remodeling Laundry Area			1997	5,400	1,173	39	1,173		3,510	23
24	Remodeling Laundry Area			1997	19,779	4,280	39	4,280		12,795	24
25	Handrails			1997	5,750	1,228	39	1,228		3,663	25
26	Fire Alarm			1997	16,726	3,316	39	3,316		10,443	26
27	Light Fixtures			1997	6,552	594	39	594		6,282	27
28	Boiler			1997	925	197	39	197		588	28
29	Kitchen Improvements			1997	2,875	610	39	610		1,819	29
30	Elevator			1997	2,300	483	39	483		1,439	30
31	Bathroom Remodeling			1997	312	65	39	65		194	31
32	HVAC, Boiler			1997	14,915	3,027	39	3,027		8,967	32
33	Ward Doors			1998	2,803	562	39	562		1,662	33
34	Concrete Steps			1998	2,500	507	39	507		1,502	34
35	Fire Alarm			1998	16,000	3,090	39	3,090		9,088	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Boiler and Duckwork	1999	$ 18,500	$ 3,639	39	$ 3,639	$	$ 10,305	37
38	Windows	1999	1,498	292	39	292		862	38
39	Cooling Tower	2000	8,860	1,624	39	1,624		4,737	39
40	Heater	2000	3,000	534	39	534		1,550	40
41	Vestibule Remodeling	2001	4,200	740	39	740		2,147	41
42	Elevator	2002	1,500	246	39	246		705	42
43	Carpet	2002	1,500	246	39	246		705	43
44	A/C Unit	2003	24,800		5			24,800	44
45	Elevator Hydraulic Power Unit	2006	14,000	1,573	39	1,573		4,116	45
46	Water Heater	2006	3,900	435	39	435		1,135	46
47	Wet Che Supression System	2006	2,225	248	39	248		647	47
48	Colling Tower Slinger Assemble	2006	2,400	285	39	285		759	48
49	Motor Starter on Cooling Tower	2006	1,117	128	39	128		335	49
50	Pump Motor on Hot Water Heater	2006	1,406	170	39	170		455	50
51	Kitchen Exhaust Fan	2007	4,848	518	39	518		1,335	51
52	80 Ton Cooling Tower	2007	85,500	8,762	39	8,762		22,280	52
53	New Brick for Chimney	2007	5,500	564	39	564		1,434	53
54	Concret Stairs	2007	6,500	660	39	660		1,671	54
55	Sump Pump	2007	3,600	383	39	383		987	55
56	Water Heater	2008	5,200	473	39	473		1,149	56
57	Valves	2010	4,500	345	39	345		777	57
58	Sprinkler System Heads & Valves	2011	3,330	198	39	198		384	58
59	Elevator Project	2012	20,912	1,190	39	1,190		2,174	59
60	Pump	2012	2,500	126	39	126		168	60
61	Fire Dampers in Ducts	2012	5,000	258	39	258		364	61
62	Door Project	2012	58,002	2,835	39	2,835		3,331	62
63	Water Pump	2012	3,017	153	39	153		205	63
64	Heating System	2013	51,200	2,136	39	2,136		2,792	64
65	Water Heater	2013	6,599	293	39	293		420	65
66	Water Heater	2013	10,800	414	39	414		460	66
67	Wiring Upgrade	2014	7,511	205	27.5	205		205	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,514,501	$ 57,060		$ 57,332	$ 272	$ 1,188,635	70

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 28,464	$ 2,042	$ 2,042	$	5-7	$ 28,268	71
72	Current Year Purchases	10,719	1,584	1,584		5	1,584	72
73	Fully Depreciated Assets	198,256					198,256	73
74	Mng Company and RE Prt		15,568	15,568				74
75	TOTALS	$ 237,439	$ 19,194	$ 19,194	$		$ 228,108	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)	$ 1,842,370	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 76,254	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 76,526	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 272	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,416,743	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: 01/01/2014 Ending: 12/31/2014

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. [X] 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 [X] NO Terms: Annual Lease *

10. Effective dates of current rental agreement:
Beginning 01/01/2014
Ending 12/31/2014

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 2,645 Description: Copier - $1,673; Ice Maker - $972; Management Company - $85
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2012 Subaru Outback	$ 509.00	$ 5,111	17
18	Administrative	2015 Suburu Outback	495.00	495	18
19					19
20					20
21	TOTAL		$ #######	$ 5,606	21

* 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.

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			407,227			407,227	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory	39-2					2,609		2,609	12
13	Other (specify):									13
14	TOTAL			$		$ 407,227	$ 2,609		$ 409,836	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.

STATE OF ILLINOIS

Facility Name & ID Number Balmoral Home **#** 0039966 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2014 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 442,621	$ 442,621	1
2	Cash-Patient Deposits	8,786	8,786	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	964,065	964,065	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	116,738	116,738	6
7	Other Prepaid Expenses	32,033	32,033	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,564,243	$ 1,564,243	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	482,376	482,376	15
16	Equipment, at Historical Cost	284,514	284,514	16
17	Accumulated Depreciation (book methods)	(433,000)	(1,418,048)	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)**	$ 333,890	$ 424,320	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,898,133	$ 1,988,563	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 250,279	$ 250,279	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,832	8,832	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,824	23,824	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	12,998	12,998	35
	Other Current Liabilities(specify):			
36	Attached Schedule	2,730,396	2,730,396	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,276,329	$ 3,276,329	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,276,329	$ 3,276,329	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,378,196)	$ (1,287,766)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,898,133	$ 1,988,563	48

***(See instructions.)**

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 61,296	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 61,293	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	936,511	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	(2,376,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,439,489)	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)**	$ (1,378,196)	24 *

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,869,861	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,869,861	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	73,834	6
7	Oxygen	3,959	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 77,793	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,368	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,368	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Attached Schedule	140,139	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 140,139	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,097,161	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,402,328	31
32	Health Care	2,514,971	32
33	General Administration	2,209,253	33
	B. Capital Expense		
34	Ownership	2,083,359	34
	C. Ancillary Expense		
35	Special Cost Centers	409,836	35
36	Provider Participation Fee	525,652	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,145,399	40
41	**Income before Income Taxes (line 30 minus line 40)****	951,762	41
42	**Income Taxes**	(15,251)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 936,511	43

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

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

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

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

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	694	694	$ 9,231	$ 13.30	1
2	Assistant Director of Nursing	3,091	3,430	157,470	45.91	2
3	Registered Nurses	21,809	23,436	626,577	26.74	3
4	Licensed Practical Nurses	4,344	4,664	100,710	21.59	4
5	CNAs & Orderlies	76,540	80,881	772,530	9.55	5
6	CNA Trainees					6
7	Licensed Therapist	3,851	4,235	64,876	15.32	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,972	2,196	39,841	18.14	9
10	Activity Assistants	8,077	8,824	112,632	12.76	10
11	Social Service Workers	11,896	12,264	212,121	17.30	11
12	Dietician					12
13	Food Service Supervisor	2,288	2,472	55,831	22.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,965	25,362	266,548	10.51	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	18,495	20,163	205,354	10.18	18
19	Laundry	8,188	9,188	96,991	10.56	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,169	3,377	26,792	7.93	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	4,006	4,363	47,258	10.83	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	191,385	205,549	$ 2,794,762 *	$ 13.60	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 10,930	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	675	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L	1,728	10-3A	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	550	12-3	45
46	Other(specify) Psycho Social	S	1,325	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,208		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 126,980	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 126,980		53

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Management Fees	$ 1,178,618
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,178,618
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Attached Schedule		$ 83,489
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 83,489

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,609
Unemployment Compensation Insurance	17,223
FICA Taxes	218,586
Employee Health Insurance	201,101
Employee Meals	27,964
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical Exams	600
Union Pension	24,093
Allocation from Management Company	75,773
TOTAL (agree to Schedule V, line 22, col.8)	$ 635,949

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,975
Health Care Worker Background Check	
(Indicate # of checks performed 17)	553
Patient Background Checks 97	1,631
Advertising and Promotions	34,609
Dues & Subscriptions	1,272
Licenses & Permits	1,296
Allocation from Management Company	2,827
Less: Public Relations Expense	( )
Non-allowable advertising	(34,609)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,554

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,960
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,960

**See instructions.

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Balmoral Home # 0039966 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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. $ **525,652**
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. $ **27,964** 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) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees