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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 01/01/2016 to 12/31/2016 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: 01/01/2016 Ending: 12/31/2016

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	77,958	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	77,958	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	68,793	471	4,360	73,624	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,793	471	4,360	73,624	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.44%

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 [X]

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 3,737

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	340,589	29,796	5,857	376,242		376,242		376,242			1
2	Food Purchase		359,404		359,404	(27,341)	332,063	(262)	331,801			2
3	Housekeeping	149,672	45,470		195,142		195,142		195,142			3
4	Laundry	102,122	5,483		107,605		107,605		107,605			4
5	Heat and Other Utilities			180,895	180,895		180,895	4,999	185,894			5
6	Maintenance	29,680	81,167		110,847		110,847	33,131	143,978			6
7	Other (specify):* Attached Schedule			24,003	24,003		24,003	152	24,155			7
8	TOTAL General Services	622,063	521,320	210,755	1,354,138	(27,341)	1,326,797	38,020	1,364,817			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,920,155	188,897	54,925	2,163,977		2,163,977		2,163,977			10
10a	Therapy	57,100			57,100		57,100		57,100			10a
11	Activities	103,925	1,500		105,425		105,425		105,425			11
12	Social Services	220,465	3,387		223,852		223,852		223,852			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	63,921			63,921		63,921		63,921			15
16	TOTAL Health Care and Programs	2,365,566	193,784	54,925	2,614,275		2,614,275		2,614,275			16
	C. General Administration											
17	Administrative	50,633		671,262	721,895		721,895	(283,498)	438,397			17
18	Directors Fees											18
19	Professional Services			109,339	109,339		109,339	5,801	115,140			19
20	Dues, Fees, Subscriptions & Promotions			36,329	36,329		36,329	(25,220)	11,109			20
21	Clerical & General Office Expenses			124,241	124,241		124,241	69,274	193,515			21
22	Employee Benefits & Payroll Taxes			540,160	540,160	27,341	567,501	51,709	619,210			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,169	1,169		1,169	952	2,121			24
25	Other Admin. Staff Transportation			2,150	2,150		2,150	(1,451)	699			25
26	Insurance-Prop.Liab.Malpractice			241,004	241,004		241,004	2,245	243,249			26
27	Other (specify):*											27
28	TOTAL General Administration	50,633		1,725,654	1,776,287	27,341	1,803,628	(180,188)	1,623,440			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,038,262	715,104	1,991,334	5,744,700		5,744,700	(142,168)	5,602,532			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: 01/01/2016 Ending: 12/31/2016

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			18,696	18,696		18,696	5,524	24,220			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							234,694	234,694			33
34	Rent-Facility & Grounds			2,024,727	2,024,727		2,024,727	(2,024,727)				34
35	Rent-Equipment & Vehicles			13,503	13,503		13,503	277	13,780			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,056,926	2,056,926		2,056,926	(1,784,232)	272,694			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			414,292	414,292		414,292		414,292			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			536,697	536,697		536,697		536,697			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			950,989	950,989		950,989		950,989			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,038,262	715,104	4,999,249	8,752,615		8,752,615	(1,926,400)	6,826,215			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: 01/01/2016 Ending: 12/31/2016

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				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	(262)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(1,599)	25		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(230)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(1,342)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(97,421)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(27,555)	20		28
29	Other-Attach Schedule See Attached Schedule	(376)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (128,785)		$	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)	(1,797,615)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,797,615)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,926,400)		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: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Franchise Tax	$ (100)	21	1
2	Trust Fees	(75)	21	2
3	Interest Income in Excess of Interest Expense	2	32	3
4	Sales Tax (Management Company)	(203)	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	**Total**	(376)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(465)	0	203	0	0	0	0	0	0	0	0	(262)	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	4,999	0	0	0	0	0	0	0	0	0	4,999	5
6	Maintenance	0	2,192	30,939	0	0	0	0	0	0	0	0	33,131	6
7	Other (specify):*	0	152	0	0	0	0	0	0	0	0	0	152	7
8	**TOTAL General Services**	(465)	7,343	31,142	0	0	0	0	0	0	0	0	38,020	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	(283,498)	0	0	0	0	0	0	0	0	(283,498)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	5,801	0	0	0	0	0	0	0	0	5,801	19
20	Fees, Subscriptions & Promotions	(27,555)	2,186	149	0	0	0	0	0	0	0	0	(25,220)	20
21	Clerical & General Office Expenses	(99,168)	16,322	152,120	0	0	0	0	0	0	0	0	69,274	21
22	Employee Benefits & Payroll Taxes	0	51,709	0	0	0	0	0	0	0	0	0	51,709	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	952	0	0	0	0	0	0	0	0	952	24
25	Other Admin. Staff Transportation	(1,599)	121	27	0	0	0	0	0	0	0	0	(1,451)	25
26	Insurance-Prop.Liab.Malpractice	0	2,245	0	0	0	0	0	0	0	0	0	2,245	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(128,322)	72,583	(124,449)	0	0	0	0	0	0	0	0	(180,188)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(128,787)	79,926	(93,307)	0	0	0	0	0	0	0	0	(142,168)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Balmoral Home # 0039966 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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	0	0	5,524	0	0	0	0	0	0	0	0	5,524	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	2	0	(2)	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	9,967	224,727	0	0	0	0	0	0	0	234,694	33
34	Rent-Facility & Grounds	0	14,707	(14,707)	(2,024,727)	0	0	0	0	0	0	0	(2,024,727)	34
35	Rent-Equipment & Vehicles	0	0	277	0	0	0	0	0	0	0	0	277	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2	14,707	1,059	(1,800,000)	0	0	0	0	0	0	0	(1,784,232)	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)**	(128,785)	94,633	(92,248)	(1,800,000)	0	0	0	0	0	0	0	(1,926,400)	45

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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			
		Central Nursing Home, LLC	Chicago			

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%	$ 121	$ 121	1
2	V	20	Advertising		Nivram Management, Inc.	100.00%	265	265	2
3	V	21	Bank Charges		Nivram Management, Inc.	100.00%	107	107	3
4	V	6	Repairs & Maintenance		Nivram Management, Inc.	100.00%	2,192	2,192	4
5	V	5	Utilities		Nivram Management, Inc.	100.00%	4,999	4,999	5
6	V	21	Office Expense		Nivram Management, Inc.	100.00%	16,057	16,057	6
7	V	20	Dues & Subscriptions		Nivram Management, Inc.	100.00%	1,921	1,921	7
8	V	21	Taxes-Other		Nivram Management, Inc.	100.00%	158	158	8
9	V	22	Payroll Taxes		Nivram Management, Inc.	100.00%	36,024	36,024	9
10	V	34	Rent		Nivram Management, Inc.	100.00%	14,707	14,707	10
11	V	26	Insurance		Nivram Management, Inc.	100.00%	2,245	2,245	11
12	V	22	Health Insurance		Nivram Management, Inc.	100.00%	15,685	15,685	12
13	V	7	Scavenger		Nivram Management, Inc.	100.00%	152	152	13
14	Total			$			$ 94,633	$ * 94,633	14

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	35	Rental Equipment	$	Nivram Management, Inc.	100.00%	$ 277	$ 277	15
16	V	21	Miscellaneous		Nivram Management, Inc.	100.00%	1,185	1,185	16
17	V	21	Postage		Nivram Management, Inc.	100.00%	936	936	17
18	V	2	Sales Expense		Nivram Management, Inc.	100.00%	203	203	18
19	V	20	Licenses & Permits		Nivram Management, Inc.	100.00%	149	149	19
20	V	25	Travel		Nivram Management, Inc.	100.00%	27	27	20
21	V	30	Depreciation		Nivram Management, Inc.	100.00%	297	297	21
22	V	21	Data Processing		Nivram Management, Inc.	100.00%	1,414	1,414	22
23	V	19	Outside Services		Nivram Management, Inc.	100.00%	1,147	1,147	23
24	V	24	Seminars		Nivram Management, Inc.	100.00%	952	952	24
25	V	19	Professional Fees		Nivram Management, Inc.	100.00%	2,847	2,847	25
26	V	6	Plant Supervisor Salary		Nivram Management, Inc.	100.00%	30,939	30,939	26
27	V	17	Asst. Administrator Salary		Nivram Management, Inc.	100.00%	165,162	165,162	27
28	V	21	Office Manager Salary		Nivram Management, Inc.	100.00%	28,640	28,640	28
29	V	17	Administrative Salaries		Nivram Management, Inc.	100.00%	68,383	68,383	29
30	V	17	Administrator Salary		Nivram Management, Inc.	100.00%	154,219	154,219	30
31	V	21	Clerical Salaries		Nivram Management, Inc.	100.00%	119,851	119,851	31
32	V	17	Management Fees	671,262	Nivram Management, Inc.	100.00%		(671,262)	32
33	V	34	Rental Income	14,707	Hamlin Arthur Building Partnership	100.00%		(14,707)	33
34	V	32	Interest Incomce	2	Hamlin Arthur Building Partnership	100.00%		(2)	34
35	V	21	Bank Fees		Hamlin Arthur Building Partnership	100.00%	94	94	35
36	V	30	Depreciation		Hamlin Arthur Building Partnership	100.00%	5,227	5,227	36
37	V	19	Legal Fees		Hamlin Arthur Building Partnership	100.00%	1,807	1,807	37
38	V	33	Real Estate Taxes		Hamlin Arthur Building Partnership	100.00%	9,967	9,967	38
39	Total			$ 685,971			$ 593,723	$ * (92,248)	39

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	34	Rental Income	$ 2,024,727		100.00%	$	$ (2,024,727)	15
16	V	33	Real Estate Taxes			100.00%	224,727	224,727	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	Total			$ 2,024,727			$ 224,727	$ * (1,800,000)	39

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 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			$			$	$	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	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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	150,000	10	25.00	Salary	$ 50,000	17-7	1
2	Marvin Mermelstein	Plant Supervisor	Support	50.00	95,286	4	24.51	Salary	30,939	1-7	2
3	Doreen Mermelstein	Office Manager	Administrative	0.00	85,920	10	25.00	Salary	28,640	21-7	3
4	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	142,929	7	24.51	Salary	46,408	17-7	4
5	Joseph Mermelstein	Owner	Administrative	50.00	56,617	3	24.51	Salary	18,383	17-7	5
6	Daniel Mermelstein	Clerical	Clerical	0.00	3,020	2	24.53	Salary	980	21-7	6
7	Gavriel Mermelstein	Clerical	Clerical	0.00	3,020	2	24.53	Salary	980	21-7	7
8	Joshua Mermelstein	Clerical	Clerical	0.00	7,134	3	24.44	Salary	2,316	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 178,646		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: 01/01/2016 Ending: 2/31/2016

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	869	4	$ 496	$	213	$ 122	1
2	20	Advertising	Resident Beds	869	4	1,081		213	265	2
3	21	Bank Charges	Resident Beds	869	4	438		213	107	3
4	6	Repairs & Maintenance	Resident Beds	869	4	8,945		213	2,193	4
5	5	Utilities	Resident Beds	869	4	20,395		213	4,999	5
6	21	Office Expense	Resident Beds	869	4	65,511		213	16,057	6
7	20	Dues & Subscriptions	Resident Beds	869	4	7,837		213	1,921	7
8	21	Taxes - Other	Resident Beds	869	4	645		213	158	8
9	22	Payroll Taxes	Resident Beds	869	4	146,970		213	36,024	9
10	34	Rent	Resident Beds	869	4	60,000		213	14,707	10
11	26	Insurance	Resident Beds	869	4	9,159		213	2,245	11
12	22	Health Insurance	Resident Beds	869	4	63,991		213	15,685	12
13	7	Scavenger	Resident Beds	869	4	619		213	152	13
14	35	Rental Equipment	Resident Beds	869	4	1,130		213	277	14
15	21	Miscellaneous	Resident Beds	869	4	4,832		213	1,184	15
16	21	Postage	Resident Beds	869	4	3,820		213	936	16
17	2	Sales Expense	Resident Beds	869	4	828		213	203	17
18	20	Licenses & Permits	Resident Beds	869	4	608		213	149	18
19	25	Travel	Resident Beds	869	4	111		213	27	19
20	30	Depreciation	Resident Beds	869	4	1,215		213	298	20
21	21	Data Processing	Resident Beds	869	4	5,768		213	1,414	21
22	19	Outside Services	Resident Beds	869	4	4,680		213	1,147	22
23	24	Seminars	Resident Beds	869	4	3,883		213	952	23
24	19	Professional Fees	Resident Beds	869	4	11,614		213	2,847	24
25	TOTALS					$ 424,576	$		$ 104,069	25

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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	6	Plant Supervisor Salary	Direct Cost	1	1	$ 30,939	$ 30,939	1	$ 30,939	1
2	17	Asst. Administrator Salary	Direct Cost	1	1	165,162	165,162	1	165,162	2
3	21	Office Manager Salary	Direct Cost	1	1	28,640	28,640	1	28,640	3
4	17	Administrative Salaries	Direct Cost	1	1	68,383	68,383	1	68,383	4
5	17	Administrator Salary	Direct Cost	1	1	154,219	154,219	1	154,219	5
6	21	Clerical Salaries	Direct Cost	1	1	119,851	119,851	1	119,851	6
7	21	Bank Fees	Resident Beds	869	4	383		213	94	7
8	30	Depreciation	Resident Beds	869	4	21,325		213	5,227	8
9	19	Legal Fees	Resident Beds	869	4	7,372		213	1,807	9
10	33	Real Estate Taxes	Resident Beds	869	4	40,663		213	9,967	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					$ 636,937	$ 567,194		$ 584,289	25

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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:** 01/01/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	$	234,694	2
3. Under or (over) accrual (line 2 minus line 1).	$	(15,306)	3
4. Real Estate Tax accrual used for 2016 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.	$	234,694	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	261,570	8
	2012	246,679	9
	2013	214,422	10
	2014	218,741	11
	2015	224,727	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-07-109-036-0000	Nursing Home	$ 224,726.90	$ 224,726.90
2.	10-35-325-029-0000	Management Co. Building	$ 4,426.35	$ 933.05
3.	10-35-325-015-0000	Management Co. Building	$ 42,856.70	$ 9,033.94
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 272,009.95	$ 234,693.89

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

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).

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: 01/01/2016 Ending: 12/31/2016

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	309	39	309		7,123	9
10	Fence			1994	2,700	98	39	98		2,161	10
11	Leasehold Improvements			1995	4,813	175	39	175		3,710	11
12	Leasehold Improvements			1996	3,750		10			3,750	12
13	Fire Alarm			1996	8,750	318	39	318		6,665	13
14	Laundry Chute			1996	2,181	80	39	80		1,658	14
15	Concrete Ramp			1996	2,500	91	39	91		1,859	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	215	39	215		4,317	21
22	Parking Lot			1997	6,600	233	20	233		6,600	22
23	Remodeling Laundry Area			1997	5,400	196	39	196		3,902	23
24	Remodeling Laundry Area			1997	19,779	719	39	719		14,233	24
25	Handrails			1997	5,750	209	39	209		4,081	25
26	Fire Alarm			1997	16,726	560	39	560		11,563	26
27	Light Fixtures			1997	6,552	104	39	104		6,490	27
28	Boiler			1997	925	33	39	33		654	28
29	Kitchen Improvements			1997	2,875	104	39	104		2,027	29
30	Elevator			1997	2,300	84	39	84		1,607	30
31	Bathroom Remodeling			1997	312	12	39	12		218	31
32	Ward Doors			1998	2,803	101	39	101		1,864	32
33	Concrete Steps			1998	2,500	91	39	91		1,684	33
34	Fire Alarm			1998	16,000	620	39	620		10,252	34
35											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: 01/01/2016 Ending: 12/31/2016

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	$ 673	39	$ 673	$	$ 11,651	37
38	Windows	1999	1,498	54	39	54		970	38
39	Cooling Tower	2000	8,860	323	39	323		5,383	39
40	Heater	2000	3,000	109	39	109		1,768	40
41	Vestibule Remodeling	2001	4,200	153	39	153		2,453	41
42	Elevator	2002	1,500	54	39	54		813	42
43	Carpet	2002	1,500	54	39	54		813	43
44	A/C Unit	2003	24,800		5			24,800	44
45	Elevator Hydraulic Power Unit	2006	14,000	509	39	509		5,134	45
46	Wet Che Supression System	2006	2,225	81	39	81		809	46
47	Colling Tower Slinger Assemble	2006	2,400	87	39	87		933	47
48	Motor Starter on Cooling Tower	2006	1,117	41	39	41		417	48
49	Kitchen Exhaust Fan	2007	4,848	177	39	177		1,689	49
50	80 Ton Cooling Tower	2007	85,500	3,110	39	3,110		28,500	50
51	New Brick for Chimney	2007	5,500	200	39	200		1,834	51
52	Concret Stairs	2007	6,500	237	39	237		2,145	52
53	Valves	2010	4,500	163	39	163		1,103	53
54	Sprinkler System Heads & Valves	2011	3,330	122	39	122		628	54
55	Elevator Project	2012	20,912	761	39	761		3,696	55
56	Fire Dampers in Ducts	2012	5,000	182	39	182		728	56
57	Door Project	2012	58,002	2,109	39	2,109		7,549	57
58	Heating System	2013	51,200	1,862	39	1,862		6,516	58
59	Water Heater	2013	6,599	240	39	240		900	59
60	Water Heater	2013	10,800	393	39	393		1,246	60
61	Wiring Upgrade	2014	7,511	273	27.5	273		751	61
62	Firepump phase reversal	2015	4,350	158	27.5	158		290	62
63	Carpet	2016	6,150	75	27.5	75		75	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,490,463	$ 16,552		$ 16,552	$	$ 1,208,534	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: 01/01/2016 Ending: 12/31/2016

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	$ 39,183	$ 2,143	$ 2,143	$	5-7	$ 39,183	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	198,256					198,256	73
74	Mgmt Company & RE Ptr		5,525	5,525				74
75	TOTALS	$ 237,439	$ 7,668	$ 7,668	$		$ 237,439	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)	$ 1,818,332	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,220	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,220	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,445,973	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: 01/01/2016 Ending: 12/31/2016

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 01/01/2016
Ending 12/31/2016

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 3,116 Description: Copier - $1,858, Ice Maker - $981, Mgmt Co - 277
(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	2015 Subaru Outback	$ 495.00	$ 5,947	17
18	Administrative	2016 Hyundai Santa Fe	361.00	4,717	18
19					19
20					20
21	TOTAL		$ 856.00	$ 10,664	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: 01/01/2016 Ending: 12/31/2016

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			414,292			414,292	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):									12
13	Other (specify):									13
14	TOTAL			$		$ 414,292	$		$ 414,292	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: 01/01/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 (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	$ 330,049	$ 330,049	1
2	Cash-Patient Deposits	4,675	4,675	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,711,577	1,711,577	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,734	114,734	6
7	Other Prepaid Expenses	2,332	2,332	7
8	Accounts Receivable (owners or related parties)	32,447	32,447	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,195,814	$ 2,195,814	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	458,338	458,338	15
16	Equipment, at Historical Cost	284,514	284,514	16
17	Accumulated Depreciation (book methods)	(457,715)	(1,442,763)	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): Deposit	35,000	35,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 320,137	$ 410,567	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,515,951	$ 2,606,381	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 208,572	$ 208,572	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,877	17,877	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,859	54,859	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	250,000	250,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Attached Schedule	3,707,430	3,707,430	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,238,738	$ 4,238,738	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)**	$ 4,238,738	$ 4,238,738	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,722,787)	$ (1,632,357)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,515,951	$ 2,606,381	48

*(See instructions.)

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,279,274)	1
2	Restatements (describe):		2
3	Rounding	(4)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,279,278)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,216,491	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	(660,000)	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)**	$ 556,491	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)**	$ (1,722,787)	24 *

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 9,847,506	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,847,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	105,030	6
7	Oxygen	4,479	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 109,509	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***	5,844	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,844	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Attached Schedule	11,436	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,436	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,974,295	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,264,845	31
32	Health Care	2,116,964	32
33	General Administration	2,362,891	33
	B. Capital Expense		
34	Ownership	2,056,925	34
	C. Ancillary Expense		
35	Special Cost Centers	414,292	35
36	Provider Participation Fee	536,697	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,752,614	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,221,681	41
42	**Income Taxes**	(5,190)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,216,491	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: 01/01/2016 Ending: 12/31/2016

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	1,912	2,072	$ 90,569	$ 43.71	1
2	Assistant Director of Nursing	1,534	1,637	46,568	28.45	2
3	Registered Nurses	28,634	30,654	821,800	26.81	3
4	Licensed Practical Nurses	3,185	3,529	83,245	23.59	4
5	CNAs & Orderlies	65,818	68,544	787,279	11.49	5
6	CNA Trainees					6
7	Licensed Therapist	1,999	2,132	57,100	26.78	7
8	Rehab/Therapy Aides	3,475	3,729	60,456	16.21	8
9	Activity Director	1,779	2,035	38,366	18.85	9
10	Activity Assistants	5,610	6,104	65,559	10.74	10
11	Social Service Workers	9,998	10,414	220,465	21.17	11
12	Dietician	2,232	2,447	59,613	24.36	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,849	25,969	280,976	10.82	15
16	Dishwashers					16
17	Maintenance Workers	1,980	2,108	29,680	14.08	17
18	Housekeepers	12,734	14,269	149,672	10.49	18
19	Laundry	8,095	8,987	102,122	11.36	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,054	3,277	50,633	15.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,012	2,175	30,238	13.90	31
32	Other Health C: MDS	2,186	2,392	63,921	26.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,086	192,474	$ 3,038,262 *	$ 15.79	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		$ 5,857	1-3	35
36	Medical Director				36
37	Medical Records Consultant		54,450	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psycho Social		475	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 60,782		49

C. CONTRACT NURSES

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 671,262
TOTAL (agree to Schedule V, line 17, col. 3)	$ 671,262
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Attached Schedule		109,339
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 109,339

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,537
Unemployment Compensation Insurance	13,682
FICA Taxes	229,378
Employee Health Insurance	190,816
Employee Meals	27,341
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	27,747
Allocation from Management Company	51,709
TOTAL (agree to Schedule V, line 22, col.8)	$ 619,210

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	598
Health Care Worker Background Check	
(Indicate # of checks performed 15)	615
Patient Background Checks 165	2,476
Advertising	29,570
Dues & Subscriptions	1,351
Licenses & Permits	1,719
Allocation from Management Company	2,335
Less: Public Relations Expense	( )
Non-allowable advertising	(27,555)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,109

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,169
Allocation from Management Company	952
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,121

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. $ **536,697**
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. $ **27,341** 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees