FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

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 01/01/2017 to 12/31/2017 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) Wipfli LLP, 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: 01/01/2017 Ending: 12/31/2017

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	67,516	502	3,229	71,247	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,516	502	3,229	71,247	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.64%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 3,478

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: 01/01/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	384,909	36,564	13,624	435,097		435,097		435,097			1
2	Food Purchase		346,111		346,111	(27,137)	318,974	(283)	318,691			2
3	Housekeeping	195,039	36,742		231,781		231,781		231,781			3
4	Laundry	113,585	1,425		115,010		115,010		115,010			4
5	Heat and Other Utilities			176,443	176,443		176,443	4,751	181,194			5
6	Maintenance	32,147	70,756		102,903		102,903	36,494	139,397			6
7	Other (specify):* Attached Schedule			23,545	23,545		23,545	236	23,781			7
8	**TOTAL General Services**	725,680	491,598	213,612	1,430,890	(27,137)	1,403,753	41,198	1,444,951			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,125,171	182,079	113,997	2,421,247		2,421,247		2,421,247			10
10a	Therapy	64,312			64,312		64,312		64,312			10a
11	Activities	109,973	1,800		111,773		111,773		111,773			11
12	Social Services	276,703	3,277		279,980		279,980		279,980			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,576,159	187,156	113,997	2,877,312		2,877,312		2,877,312			16
	C. General Administration											
17	Administrative			808,286	808,286		808,286	(397,012)	411,274			17
18	Directors Fees											18
19	Professional Services			244,910	244,910		244,910	6,608	251,518			19
20	Dues, Fees, Subscriptions & Promotions			36,120	36,120		36,120	(23,995)	12,125			20
21	Clerical & General Office Expenses	77,670		134,256	211,926		211,926	158,599	370,525			21
22	Employee Benefits & Payroll Taxes			629,009	629,009	27,137	656,146	71,097	727,243			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,523	2,523		2,523		2,523			24
25	Other Admin. Staff Transportation			7,661	7,661		7,661	(695)	6,966			25
26	Insurance-Prop.Liab.Malpractice			265,353	265,353		265,353	1,177	266,530			26
27	Other (specify):*											27
28	**TOTAL General Administration**	77,670		2,128,118	2,205,788	27,137	2,232,925	(184,221)	2,048,704			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,379,509	678,754	2,455,727	6,513,990		6,513,990	(143,023)	6,370,967			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: 01/01/2017 Ending: 12/31/2017

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			20,168	20,168		20,168	12,879	33,047			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							15,353	15,353			32
33	Real Estate Taxes							252,433	252,433			33
34	Rent-Facility & Grounds			2,045,628	2,045,628		2,045,628	(2,045,628)				34
35	Rent-Equipment & Vehicles			17,310	17,310		17,310	293	17,603			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,083,106	2,083,106		2,083,106	(1,764,670)	318,436			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			163,067	163,067		163,067		163,067			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			528,096	528,096		528,096		528,096			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			691,163	691,163		691,163		691,163			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,379,509	678,754	5,229,996	9,288,259		9,288,259	(1,907,693)	7,380,566			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: 01/01/2017 Ending: 12/31/2017

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	15,353	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(283)	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	(1,541)	21		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	(87,372)	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	(28,939)	20		28
29	Other-Attach Schedule	(638)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (105,019)		$	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)	(1,802,674)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,802,674)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,907,693)		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: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Franchise Tax	$ (100)	21	1
2	Trust Fees	(268)	21	2
3	Interest Income Mgmt Co	2	32	3
4	Sales Tax (Management Company)	(272)	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**	(638)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Balmoral Home # 0039966 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(555)	0	272	0	0	0	0	0	0	0	0	(283)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,044	1,707	0	0	0	0	0	0	0	0	4,751	5
6	Maintenance	0	2,410	34,084	0	0	0	0	0	0	0	0	36,494	6
7	Other (specify):*	0	0	236	0	0	0	0	0	0	0	0	236	7
8	**TOTAL General Services**	(555)	5,454	36,299	0	0	0	0	0	0	0	0	41,198	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	(397,012)	0	0	0	0	0	0	0	0	(397,012)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,157	2,451	0	0	0	0	0	0	0	0	6,608	19
20	Fees, Subscriptions & Promotions	(28,939)	4,785	159	0	0	0	0	0	0	0	0	(23,995)	20
21	Clerical & General Office Expenses	(89,281)	3,858	244,022	0	0	0	0	0	0	0	0	158,599	21
22	Employee Benefits & Payroll Taxes	0	0	71,097	0	0	0	0	0	0	0	0	71,097	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	(1,599)	152	752	0	0	0	0	0	0	0	0	(695)	25
26	Insurance-Prop.Liab.Malpractice	0	1,177	0	0	0	0	0	0	0	0	0	1,177	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(119,819)	14,129	(78,531)	0	0	0	0	0	0	0	0	(184,221)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(120,374)	19,583	(42,232)	0	0	0	0	0	0	0	0	(143,023)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Balmoral Home # 0039966 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	7,652	5,227	0	0	0	0	0	0	0	0	12,879	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	15,355	0	(2)	0	0	0	0	0	0	0	0	15,353	32
33	Real Estate Taxes	0	0	6,805	245,628	0	0	0	0	0	0	0	252,433	33
34	Rent-Facility & Grounds	0	0	0	(2,045,628)	0	0	0	0	0	0	0	(2,045,628)	34
35	Rent-Equipment & Vehicles	0	293	0	0	0	0	0	0	0	0	0	293	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	15,355	7,945	12,030	(1,800,000)	0	0	0	0	0	0	0	(1,764,670)	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)**	(105,019)	27,528	(30,202)	(1,800,000)	0	0	0	0	0	0	0	(1,907,693)	45

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Mgmt, 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	20	Advertising	$	Nivram Management, Inc.	100.00%	$ 3,003	$ 3,003	1
2	V	25	Auto Expense		Nivram Management, Inc.	100.00%	152	152	2
3	V	21	Bank Charges		Nivram Management, Inc.	100.00%	92	92	3
4	V	5	Utilities		Nivram Management, Inc.	100.00%	3,044	3,044	4
5	V	6	Repairs & Maintenance		Nivram Management, Inc.	100.00%	2,410	2,410	5
6	V	19	Professional Fees		Nivram Management, Inc.	100.00%	4,157	4,157	6
7	V	30	Depreciation		Nivram Management, Inc.	100.00%	7,652	7,652	7
8	V	21	Contributions		Nivram Management, Inc.	100.00%	45	45	8
9	V	20	Dues & Subscriptions		Nivram Management, Inc.	100.00%	1,782	1,782	9
10	V	35	Equipment Rental		Nivram Management, Inc.	100.00%	293	293	10
11	V	21	Miscellaneous		Nivram Management, Inc.	100.00%	1,735	1,735	11
12	V	21	Furishing Supplies		Nivram Management, Inc.	100.00%	1,986	1,986	12
13	V	26	Insurance		Nivram Management, Inc.	100.00%	1,177	1,177	13
14	Total			$			$ 27,528	$ * 27,528	14

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	22	Health Insurance	$	Nivram Management, Inc.	100.00%	$ 24,382	$ 24,382	15
16	V	19	Legal Fees		Nivram Management, Inc.	100.00%	2,451	2,451	16
17	V	20	Licenses & Permits		Nivram Management, Inc.	100.00%	159	159	17
18	V	21	Office Expense		Nivram Management, Inc.	100.00%	5,953	5,953	18
19	V	21	Postage		Nivram Management, Inc.	100.00%	695	695	19
20	V	34	Rent		Nivram Management, Inc.	100.00%	14,707	14,707	20
21	V	2	Sales Tax		Nivram Management, Inc.	100.00%	272	272	21
22	V	7	Scavenger		Nivram Management, Inc.	100.00%	236	236	22
23	V	25	Travel		Nivram Management, Inc.	100.00%	752	752	23
24	V	22	Payroll Taxes		Nivram Management, Inc.	100.00%	46,715	46,715	24
25	V	5	Telephone		Nivram Management, Inc.	100.00%	1,707	1,707	25
26	V	6	Plant Supervisor Salary		Nivram Management, Inc.	100.00%	34,084	34,084	26
27	V	17	Asst. administrator Salary		Nivram Management, Inc.	100.00%	51,127	51,127	27
28	V	21	Office manager salary		Nivram Management, Inc.	100.00%	42,493	42,493	28
29	V	17	Administrative salaries		Nivram Management, Inc.	100.00%	18,383	18,383	29
30	V	17	Aministrator Salary		Nivram Management, Inc.	100.00%	300,937	300,937	30
31	V	21	Clerical Salaries		Nivram Management, Inc.	100.00%	194,877	194,877	31
32	V	17	Management Fees	767,459	Nivram Management, Inc.	100.00%		(767,459)	32
33	V	34	Rental Income	14,707	Hamlin Arthur Building Partnership	100.00%		(14,707)	33
34	V	32	Interest Income	2	Hamlin Arthur Building Partnership	100.00%		(2)	34
35	V	21	Bank Fees		Hamlin Arthur Building Partnership	100.00%	4	4	35
36	V	30	Depreciation		Hamlin Arthur Building Partnership	100.00%	5,227	5,227	36
37	V	33	Real estate taxes		Hamlin Arthur Building Partnership	100.00%	6,805	6,805	37
38	V								38
39	Total			$ 782,168			$ 751,966	$ * (30,202)	39

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 2,045,628		100.00%	$	$ (2,045,628)	15
16	V	33	Real estate taxes			100.00%	245,628	245,628	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			$ 2,045,628			$ 245,628	$ * (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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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									$		1
2	Marvin Mermelstein	Plant Supervisor	Support	50.00	104,973	4	24.51	Salary	34,084	1-7	2
3	Doreen Mermelstein	Office Manager	Administrative	0.00	127,479	10	25.00	Salary	42,493	21-7	3
4	Marvin Mermelstein	Asst. Administrator	Administrative	50.00	157,462	7	24.51	Salary	51,127	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	4,152	2	24.53	Salary	1,348	21-7	6
7	Gavriel Mermelstein	Clerical	Clerical	0.00	4,152	2	24.53	Salary	1,348	21-7	7
8	Joshua Mermelstein	Clerical	Clerical	0.00	17,664	3	24.44	Salary	5,736	21-7	8
9	Louise Mermelstein	Food Service Supr	Administrative	0.00	37,500	5	25.00	Salary	12,500	21-7	9
10	Joel Mermelstein	IT Manager	Administrative	0.00	78,503	10	25.00	Salary	25,490	21-7	10
11	Jeffrey Mermelstein	Clerical	Clerical	0.00	2,241	1	24.51	Salary	728	21-7	11
12	Marvin Mermelstein	Administravtive	Management	50.00	66,206	4	20.71	Mgmt Fees	40,827	17-3	12
13								TOTAL	$ 234,064		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: 01/01/2017 Ending: 2/31/2017

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	20	Advertising	Resident Beds	869	4	$ 12,253	$	213	$ 3,003	1
2	25	Auto Expense	Resident Beds	869	4	621		213	152	2
3	21	Bank Charges	Resident Beds	869	4	377		213	92	3
4	5	Utilities	Resident Beds	869	4	12,420		213	3,044	4
5	6	Repairs & Maintenance	Resident Beds	869	4	9,834		213	2,410	5
6	19	Professional Fees	Resident Beds	869	4	16,959		213	4,157	6
7	30	Depreciation	Resident Beds	869	4	31,220		213	7,652	7
8	21	Contributions	Resident Beds	869	4	185		213	45	8
9	20	Dues & Subscriptions	Resident Beds	869	4	7,270		213	1,782	9
10	35	Equipment Rental	Resident Beds	869	4	1,195		213	293	10
11	21	Miscellaneous	Resident Beds	869	4	7,077		213	1,735	11
12	21	Furishing Supplies	Resident Beds	869	4	8,101		213	1,986	12
13	26	Insurance	Resident Beds	869	4	4,802		213	1,177	13
14	22	Health Insurance	Resident Beds	869	4	99,475		213	24,382	14
15	19	Legal Fees	Resident Beds	869	4	10,000		213	2,451	15
16	20	Licenses & Permits	Resident Beds	869	4	650		213	159	16
17	21	Office Expense	Resident Beds	869	4	24,286		213	5,953	17
18	21	Postage	Resident Beds	869	4	2,835		213	695	18
19	34	Rent	Resident Beds	869	4	60,000		213	14,707	19
20	2	Sales Tax	Resident Beds	869	4	1,111		213	272	20
21	7	Scavenger	Resident Beds	869	4	963		213	236	21
22	25	Travel	Resident Beds	869	4	3,066		213	752	22
23	22	Payroll Taxes	Resident Beds	869	4	190,587		213	46,715	23
24	5	Telephone	Resident Beds	869	4	6,966		213	1,707	24
25	TOTALS					$ 512,253	$		$ 125,557	25

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	$ 34,084	$ 34,084	1	$ 34,084	1
2	17	Asst. Administraror Salary	Direct Cost	1	1	51,127	51,127	1	51,127	2
3	21	Office Manager Salary	Direct Cost	1	1	42,493	42,493	1	42,493	3
4	17	Administrative Salaries	Direct Cost	1	1	18,383	18,383	1	18,383	4
5	17	Administrator Salary	Direct Cost	1	1	300,937	300,937	1	300,937	5
6	21	Clerical Salaries	Direct Cost	1	1	194,877	194,877	1	194,877	6
7	21	Bank Fees	Resident Beds	869	4	17		213	4	7
8	30	Depreciation	Resident Beds	869	4	21,326		213	5,227	8
9	33	Real Estate Taxes	Resident Beds	869	4	27,764		213	6,805	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					$ 691,008	$ 641,901		$ 653,937	25

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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.)		$ 252,433	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,433	3
4. Real Estate Tax accrual used for 2017 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.		$ 252,433	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	246,679	8
	2013	214,422	9
	2014	218,741	10
	2015	224,727	11
	2016	245,628	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 847-580-5100 FAX #: 847-580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-07-109-036-0000	Nursing Home	$ 245,627.59	$ 245,627.59
2.	10-35-325-029-0000	Management Co. Building	$ 4,525.78	$ 954.01
3.	10-35-325-015-0000	Management Co. Building	$ 27,757.84	$ 5,851.19
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 277,911.21	$ 252,432.79

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/2017 Ending: 12/31/2017

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. [ ] (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: 01/01/2017 Ending: 12/31/2017

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		7,432	9
10	Fence			1994	2,700	98	39	98		2,260	10
11	Leasehold Improvements			1995	4,813	175	39	175		3,882	11
12	Leasehold Improvements			1996	3,750		10			3,750	12
13	Fire Alarm			1996	8,750	318	39	318		6,985	13
14	Laundry Chute			1996	2,181	79	39	79		1,735	14
15	Concrete Ramp			1996	2,500	91	39	91		1,951	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		4,533	21
22	Parking Lot			1997	6,600	136	20	136		6,600	22
23	Remodeling Laundry Area			1997	5,400	196	39	196		4,097	23
24	Remodeling Laundry Area			1997	19,779	719	39	719		14,953	24
25	Handrails			1997	5,750	209	39	209		4,292	25
26	Fire Alarm			1997	16,726	505	39	505		12,068	26
27	Light Fixtures			1997	6,552	55	39	55		6,545	27
28	Boiler			1997	925	34	39	34		688	28
29	Kitchen Improvements			1997	2,875	104	39	104		2,131	29
30	Elevator			1997	2,300	84	39	84		1,689	30
31	Bathroom Remodeling			1997	312	11	39	11		228	31
32	Ward Doors			1998	2,803	102	39	102		1,966	32
33	Concrete Steps			1998	2,500	91	39	91		1,776	33
34	Fire Alarm			1998	16,000	685	39	685		10,835	34
35	Boiler and Duckwork			1999	18,500	673	39	673		12,752	35
36	Windows			1999	1,498	54	39	54		1,022	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: 01/01/2017 Ending: 12/31/2017

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	Cooling Tower	2000	$ 8,860	$ 322	39	$ 322	$	$ 5,705	37
38	Heater	2000	3,000	109	39	109		1,877	38
39	Vestibule Remodeling	2001	4,200	152	39	152		2,603	39
40	Elevator	2002	1,500	54	39	54		866	40
41	Carpet	2002	1,500	54	39	54		866	41
42	A/C Unit	2003	24,800		5			24,800	42
43	Elevator Hydraulic Power Unit	2006	14,000	509	39	509		5,643	43
44	Wet Che Supression System	2006	2,225	80	39	80		889	44
45	Colling Tower Slinger Assemble	2006	2,400	87	39	87		1,018	45
46	Motor Starter on Cooling Tower	2006	1,117	40	39	40		460	46
47	Kitchen Exhaust Fan	2007	4,848	176	39	176		1,865	47
48	80 Ton Cooling Tower	2007	85,500	3,109	39	3,109		31,609	48
49	New Brick for Chimney	2007	5,500	200	39	200		2,034	49
50	Concret Stairs	2007	6,500	236	39	236		2,383	50
51	Valves	2010	4,500	164	39	164		1,269	51
52	Sprinkler System Heads & Valves	2011	3,330	121	39	121		747	52
53	Elevator Project	2012	20,912	761	39	761		4,500	53
54	Fire Dampers in Ducts	2012	5,000	181	39	181		985	54
55	Door Project	2012	58,002	2,109	39	2,109		10,897	55
56	Heating System	2013	51,200	1,862	39	1,862		8,378	56
57	Water Heater	2013	6,599	240	39	240		1,140	57
58	Water Heater	2013	10,800	393	39	393		1,636	58
59	Wiring Upgrade	2014	7,511	273	27.5	273		1,024	59
60	Firepump phase reversal	2015	4,350	158	27.5	158		448	60
61	Carpet	2016	6,150	223	27.5	223		298	61
62	PT Flooring	2017	8,200	199	27.5	199		199	62
63	Granite Counters	2017	13,000	236	27.5	236		236	63
64	Elevator Cylinder	2017	107,346	976	27.5	976		976	64
65	Dumb Waiter	2017	6,432	58	27.5	58		58	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,625,441	$ 18,025		$ 18,025	$	$ 1,228,101	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: 01/01/2017 Ending: 12/31/2017

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	$ 10,719	$ 2,143	$ 2,143	$	5-7	$ 8,015	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	226,720					226,720	73
74	Mgmt Co & RE Ptr		12,879	12,879				74
75	TOTALS	$ 237,439	$ 15,022	$ 15,022	$		$ 234,735	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)	$ 1,953,310	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,047	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,047	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)	$ 1,462,836	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: 01/01/2017 Ending: 12/31/2017

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 01/01/2017
Ending 12/31/2017

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 2,217 Description: Copier $1,843, Ice Maker $981, Mgmt Co. $293
(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	$ 2,973	17
18	Administrative	2016 Hyundai Santa Fe	361.00	4,328	18
19	Administrative	2017 Toyota Sienna	389.00	3,891	19
20	Administrative	2017 Subaru Outback	500.00	2,498	20
21	TOTAL		$ #######	$ 13,690	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: 01/01/2017 Ending: 12/31/2017

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			163,067			163,067	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			$		$ 163,067	$		$ 163,067	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:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 1,646,566	$ 1,646,566	1
2	Cash-Patient Deposits	28,251	28,251	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,227,018	1,227,018	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	119,424	119,424	6
7	Other Prepaid Expenses	1,328	1,328	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,022,587	$ 3,022,587	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	593,317	593,317	15
16	Equipment, at Historical Cost	284,514	284,514	16
17	Accumulated Depreciation (book methods)	(477,883)	(1,462,931)	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)**	$ 399,948	$ 490,378	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,422,535	$ 3,512,965	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 310,405	$ 310,405	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,251	28,251	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,430	70,430	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	13,070	13,070	35
	Other Current Liabilities(specify):			
36	Attached Schedule	3,213,283	3,213,283	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,885,439	$ 3,885,439	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)**	$ 3,885,439	$ 3,885,439	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (462,904)	$ (372,474)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,422,535	$ 3,512,965	48

***(See instructions.)**

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,722,787)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,722,787)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,201,483	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	(941,600)	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)**	$ 1,259,883	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)**	$ (462,904)	24 *

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 11,323,859	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,323,859	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	126,672	6
7	Oxygen	10,133	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 136,805	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***	15,353	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,353	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Attached Schedule	29,127	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 29,127	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,505,144	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,430,890	31
32	Health Care	2,877,312	32
33	General Administration	2,205,788	33
	B. Capital Expense		
34	Ownership	2,083,106	34
	C. Ancillary Expense		
35	Special Cost Centers	163,067	35
36	Provider Participation Fee	528,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,288,259	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,216,885	41
42	**Income Taxes**	(15,402)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,201,483	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: 01/01/2017 Ending: 12/31/2017

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	1,461	1,861	$ 84,483	$ 45.40	1
2	Assistant Director of Nursing	1,982	2,118	65,401	30.88	2
3	Registered Nurses	26,386	27,998	825,937	29.50	3
4	Licensed Practical Nurses	2,286	2,495	59,141	23.70	4
5	CNAs & Orderlies	63,667	66,197	854,056	12.90	5
6	CNA Trainees					6
7	Licensed Therapist	1,943	1,943	64,312	33.10	7
8	Rehab/Therapy Aides	1,890	2,098	41,394	19.73	8
9	Activity Director	2,029	2,277	38,640	16.97	9
10	Activity Assistants	5,962	6,134	71,333	11.63	10
11	Social Service Workers	10,421	11,077	276,703	24.98	11
12	Dietician					12
13	Food Service Supervisor	2,170	2,386	63,737	26.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,884	25,689	321,172	12.50	15
16	Dishwashers					16
17	Maintenance Workers	1,989	2,109	32,147	15.24	17
18	Housekeepers	14,757	15,885	195,039	12.28	18
19	Laundry	7,938	8,784	113,585	12.93	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,869	2,037	37,143	18.23	22
23	Office Manager					23
24	Clerical	1,893	2,134	40,527	18.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,769	3,893	46,382	11.91	31
32	Other Health C: MDS	4,014	4,250	122,673	28.86	32
33	Other(specify) Restorative nurse	857	857	25,703	29.99	33
34	TOTAL (lines 1 - 33)	181,167	192,222	$ 3,379,508 *	$ 17.58	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		$ 13,624	1-3	35
36	Medical Director				36
37	Medical Records Consultant		25,464	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		349	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 39,437		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 88,184		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 88,184		53

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 808,286
TOTAL (agree to Schedule V, line 17, col. 3)	$ 808,286
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Attached Schedule		$ 244,910
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 244,910

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,962
Unemployment Compensation Insurance	13,128
FICA Taxes	247,737
Employee Health Insurance	219,943
Employee Meals	27,137
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	26,239
Allocation from Management Company	71,097
TOTAL (agree to Schedule V, line 22, col.8)	$ 727,243

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	97
Health Care Worker Background Check	
(Indicate # of checks performed 44)	1,821
Patient Background Checks 143	1,430
Advertising	28,939
Licenses & Permits	3,833
Allocation from Mgmt Co	4,944
Less: Public Relations Expense	( )
Non-allowable advertising	(28,939)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,125

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,523
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,523

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. $ **N/A** 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. $ **528,096**
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. $ **27,137** 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