

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

<p>I. IDPH License ID Number: <u>0039966</u></p> <p>Facility Name: <u>Balmoral Home</u></p> <p>Address: <u>2055 W Balmoral Ave</u> <u>Chicago</u> <u>60625</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>773-561-8661</u> Fax # <u>773-561-9376</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/10/93</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mendel Schneider</u> Telephone Number: <u>847-933-1274</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%; text-align: center;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="width: 15%; text-align: center;">Paid Preparer</td> <td>(Signed) <u>See Accountant's Report Attached</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>Mendel Schneider & Associates CPA PC</u> <u>4051 Old Orchard Rd Skokie Il 60076</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u></td> </tr> <tr> <td colspan="2"> 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 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(Signed) <u>See Accountant's Report Attached</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Mendel Schneider & Associates CPA PC</u> <u>4051 Old Orchard Rd Skokie Il 60076</u>		(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>	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	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																				
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Facility Name & ID Number Balmoral Home

0039966 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	59,084	182	3,561	62,827	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,084	182	3,561	62,827	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.59%

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

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

I. On what date did you start providing long term care at this location?
Date started 10/10/93

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/10/93 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 34 and days of care provided 3,561

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Balmoral Home # 0039966 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	565,823	16,808	9,538	592,169		592,169		592,169		1
2	Food Purchase		390,569		390,569	(25,000)	365,569	(32)	365,537		2
3	Housekeeping	298,944	42,114	22,405	363,463		363,463		363,463		3
4	Laundry	54,153	5,838		59,991		59,991		59,991		4
5	Heat and Other Utilities			219,265	219,265		219,265	2,402	221,667		5
6	Maintenance	99,891		63,219	163,110		163,110	1,416	164,526		6
7	Other (specify):*										7
8	TOTAL General Services	1,018,811	455,329	314,427	1,788,567	(25,000)	1,763,567	3,786	1,767,353		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	2,867,807	179,985	199,341	3,247,133		3,247,133		3,247,133		10
10a	Therapy										10a
11	Activities	123,582	5,679		129,261		129,261		129,261		11
12	Social Services	197,607	1,107		198,714		198,714		198,714		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,188,996	186,771	202,341	3,578,108		3,578,108		3,578,108		16
	C. General Administration										
17	Administrative			1,226,013	1,226,013		1,226,013	(921,961)	304,052		17
18	Directors Fees										18
19	Professional Services			91,398	91,398		91,398	13,431	104,829		19
20	Dues, Fees, Subscriptions & Promotions			5,706	5,706		5,706	(255)	5,451		20
21	Clerical & General Office Expenses	365,562	29,648	71,607	466,817		466,817	208,431	675,248		21
22	Employee Benefits & Payroll Taxes			568,592	568,592	25,000	593,592	33,976	627,568		22
23	Inservice Training & Education										23
24	Travel and Seminar			312	312		312		312		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			220,765	220,765		220,765	2,619	223,384		26
27	Other (specify):*										27
28	TOTAL General Administration	365,562	29,648	2,184,393	2,579,603	25,000	2,604,603	(663,759)	1,940,844		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,573,369	671,748	2,701,161	7,946,278		7,946,278	(659,973)	7,286,305		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:

01/01/2020

Ending:

12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			31,695	31,695		31,695	2,154	33,849			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							285,072	285,072			33
34	Rent-Facility & Grounds			2,068,602	2,068,602		2,068,602	(2,068,602)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			52,877	52,877		52,877	(52,877)				36
37	TOTAL Ownership			2,153,174	2,153,174		2,153,174	(1,834,253)	318,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			528,911	528,911		528,911		528,911			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			481,212	481,212		481,212		481,212			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,010,123	1,010,123		1,010,123		1,010,123			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,573,369	671,748	5,864,458	11,109,575		11,109,575	(2,494,226)	8,615,349			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,154	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(32)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,877)	36		24
25	Fund Raising, Advertising and Promotional	(255)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,010)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,443,216)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,443,216)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,494,226)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Balmoral Home

ID# 0039966

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(32)	0	0	0	0	0	0	0	0	0	0	(32)	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	0	2,402	0	0	0	0	0	0	0	0	2,402	5
6	Maintenance	0	0	1,416	0	0	0	0	0	0	0	0	1,416	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(32)	0	3,818	0	0	0	0	0	0	0	0	3,786	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	(921,961)	0	0	0	0	0	0	0	0	(921,961)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	13,431	0	0	0	0	0	0	0	0	13,431	19
20	Fees, Subscriptions & Promotions	(255)	0	0	0	0	0	0	0	0	0	0	(255)	20
21	Clerical & General Office Expenses	0	0	208,431	0	0	0	0	0	0	0	0	208,431	21
22	Employee Benefits & Payroll Taxes	0	0	33,976	0	0	0	0	0	0	0	0	33,976	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,619	0	0	0	0	0	0	0	0	2,619	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(255)	0	(663,504)	0	0	0	0	0	0	0	0	(663,759)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(287)	0	(659,686)	0	0	0	0	0	0	0	0	(659,973)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	2,154	0	0	0	0	0	0	0	0	0	0	2,154	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	274,184	10,888	0	0	0	0	0	0	0	0	285,072	33
34	Rent-Facility & Grounds	0	(2,068,602)	0	0	0	0	0	0	0	0	0	(2,068,602)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(52,877)	0	0	0	0	0	0	0	0	0	0	(52,877)	36
37	TOTAL Ownership	(50,723)	(1,794,418)	10,888	0	0	0	0	0	0	0	0	(1,834,253)	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)	(51,010)	(1,794,418)	(648,798)	0	0	0	0	0	0	0	0	(2,494,226)	45

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	Central Nursing Home	Chicago	Balmoral Trust	Lincolnwood	Bldg Rental
Joseoh Mermelstein	50	Winston Manor Nursing Home	Chicago	Nivram Mgmt	Lincolnwood	Mgmt Co
		Paul House Health Care	Chicago			
		Chicago Ridge Nursing Home	Chicago Ridge			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 2,068,602	Balmoral Trust	100.00%	\$	(2,068,602)	1
2	V	33 Real Estate Taxes		Balmoral Trust		274,184	274,184	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,068,602			\$ 274,184	\$ * (1,794,418)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	\$ 1,226,013	Nivram Management Inc	100.00%	\$	\$ (1,226,013)
16	V	21 Payroll		Nivram Management Inc		126,534	126,534
17	V	22 Payroll Taxes		Nivram Management Inc		33,976	33,976
18	V	33 Real Estate Tax		Nivram Management Inc		10,888	10,888
19	V	5 Utilities		Nivram Management Inc		2,402	2,402
20	V	6 Repairs & Maintenance		Nivram Management Inc		1,416	1,416
21	V	26 Insurance		Nivram Management Inc		2,619	2,619
22	V	19 Professional Fees		Nivram Management Inc		13,431	13,431
23	V	21 Office		Nivram Management Inc		27,764	27,764
24	V	17 Marvin Mermelstein		Nivram Management Inc		18,264	18,264
25	V	21 Doreen Mermelstein		Nivram Management Inc		1,876	1,876
26	V	21 Jacob Mermelstein		Nivram Management Inc		28,284	28,284
27	V	21 Joel Mermelstein		Nivram Management Inc		23,973	23,973
28	V	17 Administrator Salary		Nivram Management Inc		170,162	170,162
29	V	17 Administrator Salary		Nivram Management Inc		115,626	115,626
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,226,013			\$ 577,215	\$ * (648,798)

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

Facility Name & ID Number

Balmoral Home

0039966

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marvin Mermelstein		Adm	50.00	65,682	10	20.00	Salary	\$ 18,264	17	1
2	Doreen Mermelstein		Clerical		6,747	10	20.00	Salary	1,876	21	2
3	Jacob Mermelstein		Clerical		101,716	10	20.00	Salary	28,284	21	3
4	Joel Mermelstein		Clerical		86,214	10	20.00	Salary	23,973	21	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 72,397		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:

01/01/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	Payroll	Resident Beds	979	5	\$ 581,580	\$ 581,580	213	\$ 126,534	1
2	22	Payroll Taxes	Resident Beds	979	5	156,164		213	33,976	2
3	33	Real Estate Tax	Resident Beds	979	5	50,044		213	10,888	3
4	5	Utilities	Resident Beds	979	5	11,038		213	2,402	4
5	6	Repair & Maintenance	Resident Beds	979	5	6,509		213	1,416	5
6	26	Insurance	Resident Beds	979	5	12,037		213	2,619	6
7	19	Professional Fees	Resident Beds	979	5	61,734		213	13,431	7
8	21	Office	Resident Beds	979	5	127,608		213	27,764	8
9	17	Marvin Mermelstein	Resident Beds	979	5	83,946	83,946	213	18,264	9
10	21	Doreen Mermelstein	Resident Beds	979	5	8,623	8,623	213	1,876	10
11	21	Jacob Mermelstein	Resident Beds	979	5	130,000	130,000	213	28,284	11
12	21	Joel Mermelstein	Resident Beds	979	5	110,187	110,187	213	23,973	12
13	17	Administrator Salary				170,162	170,162		170,162	13
14	17	Administrator Salary				115,626	115,626		115,626	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,625,258	\$ 1,200,124		\$ 577,215	25

Facility Name & ID Number

Balmoral Home

0039966

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 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.)	\$	270,385	2
3. Under or (over) accrual (line 2 minus line 1).	\$	20,385	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	264,687	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.	\$	285,072	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	224,727	8
	2016	245,628	9
	2017	264,000	10
	2018	255,133	11
	2019	259,497	12

Line 4: 259497 x 1.02

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Balmoral Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039966

CONTACT PERSON REGARDING THIS REPORT Robb Strukoff

TELEPHONE 847-941-0100 FAX #: 847-941-0101

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>14-07-109-036-0000</u>	<u>Facility</u>	\$ <u>259,496.83</u>	\$ <u>259,496.83</u>
2. _____	_____	\$ _____	\$ _____
3. <u>Allocated from Mgmt Co</u>	_____	\$ <u>50,044.00</u>	\$ <u>10,888.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>309,540.83</u></u>	\$ <u><u>270,384.83</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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:

01/01/2020 Ending:

12/31/2020

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? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [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).

Blank lines for listing other business entities.

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.

Table with 6 columns: Line Item, Use, Square Feet, Year Acquired, Cost, and another column. Row 1: Facility, 33,375, 1993, \$90,430, 1. Row 2: (blank), (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 33,375, (blank), \$90,430, 3.

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	213	1993	1968	\$ 985,048	\$		\$	\$	\$ 985,048	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Leasehold Improvements		1994	8,500	309	39	309		8,359	9
10	Fence		1994	2,700	98	39	98		2,555	10
11	Leasehold Improvements		1995	4,813	176	39	176		4,409	11
12	Leasehold Improvements		1996	3,750		10			3,750	12
13	Fire Alarm		1996	8,750	318	39	318		7,940	13
14	Laundry Chute		1996	2,181	79	39	79		1,972	14
15	Concrete Ramp		1996	2,500	91	39	91		2,224	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	270	39	270		5,233	21
22	Parking Lot		1997	6,600		20			6,600	22
23	Remodeling Laundry Area		1997	5,400	197	39	197		4,687	23
24	Remodeling Laundry Area		1997	19,779	720	39	720		17,111	24
25	Handrails		1997	5,750	210	39	210		4,920	25
26	Fire Alarm		1997	16,726	609	39	609		13,687	26
27	Light Fixtures		1997	6,552		39			6,552	27
28	Boiler		1997	925	33	39	33		788	28
29	Kitchen Improvements		1997	2,875	104	39	104		2,443	29
30	Elevator		1997	2,300	84	39	84		1,941	30
31	Bathroom Remodeling		1997	312	12	39	12		262	31
32	Ward Doors		1998	2,803	102	39	102		2,272	32
33	Concrete Steps		1998	2,500	91	39	91		2,049	33
34	Fire Alarm		1998	16,000	582	39	582		12,684	34
35	Boiler and Duckwork		1999	18,500	673	39	673		14,771	35
36	Windows		1999	1,498	55	39	55		1,186	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:

01/01/2020 Ending: 12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Cooling Tower	2000	\$ 8,860	\$ 322	39	\$ 322		\$ 6,671	37
38	Heater	2000	3,000	109	39	109		2,204	38
39	Vestibule Remodeling	2001	4,200	153	39	153		3,061	39
40	Elevator	2002	1,500	55	39	55		1,029	40
41	Carpet	2002	1,500	55	39	55		1,029	41
42	A/C Unit	2003	24,800		5			24,800	42
43	Elevator Hydraulic Power Unit	2006	14,000	508	39	508		7,168	43
44	Wet Che Suppresion System	2006	2,225	81	39	81		1,111	44
45	Colling Tower Slinger Assemble	2006	2,400	87	39	87		1,279	45
46	Motor Starter on Cooling Tower	2006	1,117	41	39	41		582	46
47	Kitchen Exhaust Fan	2007	4,848	176	39	176		2,393	47
48	80 Ton Cooling Tower	2007	85,500	3,101	39	3,101		40,920	48
49	New Brick for Chimney	2007	5,500	199	39	199		2,632	49
50	Concrete Stairs	2007	6,500	236	39	236		3,091	50
51	Valve	2010	4,500	163	39	163		1,759	51
52	Sprinkler System Heads & Valves	2011	3,330	121	39	121		1,110	52
53	Elevator Project	2012	20,912	762	39	762		6,785	53
54	Fire Dampers in Ducts	2012	5,000	181	39	181		1,528	54
55	Door Project	2012	58,002	2,113	39	2,113		17,232	55
56	Heating System	2013	51,200	1,865	39	1,865		13,970	56
57	Water Heater	2013	6,599	240	39	240		1,860	57
58	Water Heater	2013	10,800	392	39	392		2,813	58
59	Wiring Upgrade	2014	7,511	273	27.5	273		1,843	59
60	Firepump Phase Reversal	2015	4,350	158	27.5	158		922	60
61	Carpet	2016	6,150	224	27.5	224		969	61
62	PT Flooring	2017	8,200		27.5	298	298	1,093	62
63	Granite Counters	2017	13,000		27.5	473	473	1,655	63
64	Elevator Cylinder	2017	107,346		27.5	3,903	3,903	12,685	64
65	Dumb Waiter	2017	6,432		27.5	234	234	760	65
66	Elevator Project	2018	11,250	410	27.5	410		1,059	66
67	Carpet	2018	31,161	1,135	27.5	1,135		2,931	67
68	Grease Inceptor	2018	5,200	189	27.5	189		394	68
69	Kitchen Improvement/Pump	2019	25,383		15	1,692	1,692	2,538	69
70	TOTAL (lines 4 thru 69)		\$ 1,698,435	\$ 18,162		\$ 24,762	\$ 6,600	\$ 1,298,793	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 1,698,435	\$ 18,162		\$ 24,762	\$ 6,600	\$ 1,298,793	1
2	Elevator Repair	2020	2,261	2,261	15	151	(2,110)	151	2
3	Harrison Electric	2020	11,272	11,272	15	751	(10,521)	751	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,711,968	\$ 31,695		\$ 25,664	\$ (6,031)	\$ 1,299,695	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 40,927	\$	\$ 8,185	\$ 8,185	5	\$ 12,278	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	284,515					284,515	73
74								74
75	TOTALS	\$ 325,442	\$	\$ 8,185	\$ 8,185		\$ 296,793	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)	\$ 2,127,840	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,695	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,849	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,154	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,596,488	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: 01/01/2020

Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			438,919			438,919	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts			89,992			89,992	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			\$		\$ 528,911	\$		\$ 528,911	14

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

Facility Name & ID Number Balmoral Home

0039966

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,396,132	\$ 5,396,132	1
2	Cash-Patient Deposits	158,544	158,544	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	771,144	771,144	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,096	96,096	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,421,916	\$ 6,421,916	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	680,845	680,845	15
16	Equipment, at Historical Cost	325,441	325,441	16
17	Accumulated Depreciation (book methods)	(619,064)	(1,604,112)	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)	\$ 387,222	\$ 477,652	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,809,138	\$ 6,899,568	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 444,796	\$ 444,796	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	169,132	169,132	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	242,687	242,687	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,096	12,096	31
32	Accrued Real Estate Taxes(Sch.IX-B)	264,687	264,687	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrd Mgmt Fees</u>	3,113,337	3,113,337	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,246,735	\$ 4,246,735	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)	\$ 4,246,735	\$ 4,246,735	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,562,403	\$ 2,652,833	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,809,138	\$ 6,899,568	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (438,474)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (438,474)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,250,877	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,250,000)	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)	\$ 3,000,877	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)	\$ 2,562,403	24 *

* This must agree with page 17, line 47.

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

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

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,084,191	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,084,191	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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***	52,983	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 52,983	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Stimulus Income	2,223,278	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,223,278	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,360,452	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,788,567	31
32	Health Care	3,578,108	32
33	General Administration	2,579,603	33
B. Capital Expense			
34	Ownership	2,153,174	34
C. Ancillary Expense			
35	Special Cost Centers	528,911	35
36	Provider Participation Fee	481,212	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,109,575	40
41	Income before Income Taxes (line 30 minus line 40)**	4,250,877	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,250,877	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,389,889	44
45	Private Pay - Net Inpatient Revenue	40,220	45
46	Medicare - Net Inpatient Revenue	2,654,082	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,084,191	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No,CashBas 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: 01/01/2020

Ending: 12/31/2020

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,880	2,080	\$ 120,506	\$ 57.94	1
2	Assistant Director of Nursing	1,891	2,074	87,917	42.39	2
3	Registered Nurses	31,594	34,158	1,297,510	37.99	3
4	Licensed Practical Nurses	5,653	5,796	170,156	29.36	4
5	CNAs & Orderlies	56,706	60,397	1,118,389	18.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,080	2,327	73,329	31.51	8
9	Activity Director	2,032	2,272	48,763	21.46	9
10	Activity Assistants	4,654	4,961	74,819	15.08	10
11	Social Service Workers	6,994	7,505	197,607	26.33	11
12	Dietician	2,477	2,741	102,696	37.47	12
13	Food Service Supervisor					13
14	Head Cook	2,139	2,377	45,132	18.99	14
15	Cook Helpers/Assistants	23,381	24,935	417,995	16.76	15
16	Dishwashers					16
17	Maintenance Workers	4,071	4,239	99,891	23.56	17
18	Housekeepers	17,168	18,666	298,944	16.02	18
19	Laundry	2,684	3,380	54,153	16.02	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,262	5,910	143,494	24.28	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	3,481	3,803	59,197	15.57	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS</u>	4,209	4,654	162,871	35.00	33
34	TOTAL (lines 1 - 33)	178,356	192,275	\$ 4,573,369 *	\$ 23.79	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 9,538	1-3	35
36	Medical Director				36
37	Medical Records Consultant				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)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,538		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	6,640	199,341	10-3	52
53	TOTAL (lines 50 - 52)	6,640	\$ 199,341		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 55,444	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	12,394	Advertising: Employee Recruitment	159	
				FICA Taxes	333,839	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	200,891	Patient Background Checks		
				Employee Meals	25,000	Subs-Accurate Biometrics	742	
				Illinois Municipal Retirement Fund (IMRF)*		Various Subs	570	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$			Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,451	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,226,013	TOTAL (agree to Schedule V, line 22, col.8)			\$ 627,568	
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Nivram Mgmt-Mgmt Fees			\$ 1,226,013				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Various	312
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,226,013	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 312
C. Professional Services			Amount					
Vendor/Payee	Type							
Mendel Schneider CPA	Accounting		\$ 14,000					
WIPFLI	Accounting		1,730					
Compliant	Bus Mgmt Con		16,200					
Gillen,Langhenry	Legal		1,586					
Integra	Pharm Cons		11,400					
Terrill Cons	MDS Cons		31,809					
Richard Peelo	Accounting		4,200					
Govig & Assoc	Placement Fee		6,000					
Perfect Staffing	Placement Fee		4,473					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 91,398					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Balmoral Home# 0039966Report Period Beginning: 01/01/2020Ending: 12/31/2020**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. _____
- (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? _____
- (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? _____
- (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? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,000 Line 10
- (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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 481,212
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? No 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. \$ 25,000 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? _____
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.