FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0050534

Facility Name: Berkeley Nrsg & Rehab Center

Address: 6909 West North Ave (Number) Oak Park (City) 60302 (Zip Code)

County: Cook

Telephone Number: 708-236-0000 **Fax #** 708-236-0001

HFS ID Number:

Date of Initial License for Current Owners: 9/1/09

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar **Telephone Number:** 317-237-5500
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 1/1/15 to 12/31/15 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) Alan Irni
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) 317-237-5500 Fax # 317-237-5503

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 Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 N/A

	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	72	Skilled (SNF)	72	26,280	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	72	TOTALS	72	26,280	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	18,534	1,048	2,416	21,998	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,534	1,048	2,416	21,998	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.71%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

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 9/1/19

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 9/1/09 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 2,416

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	174,327	15,054	5,566	194,947		194,947		194,947			1
2	Food Purchase		111,407		111,407		111,407		111,407			2
3	Housekeeping	82,436	11,282		93,718		93,718		93,718			3
4	Laundry	37,472	3,534		41,006		41,006		41,006			4
5	Heat and Other Utilities			93,104	93,104		93,104	1,189	94,293			5
6	Maintenance	31,903	8,942	118,740	159,585		159,585	3,205	162,790			6
7	Other (specify):*											7
8	TOTAL General Services	326,138	150,219	217,410	693,767		693,767	4,394	698,161			8
	B. Health Care and Programs											
9	Medical Director			8,050	8,050		8,050		8,050			9
10	Nursing and Medical Records	1,065,752	58,474	240	1,124,466		1,124,466		1,124,466			10
10a	Therapy			294,132	294,132		294,132		294,132			10a
11	Activities	57,701	4,029		61,730		61,730		61,730			11
12	Social Services	35,603		2,837	38,440		38,440		38,440			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy consult			5,910	5,910		5,910		5,910			15
16	TOTAL Health Care and Programs	1,159,056	62,503	311,169	1,532,728		1,532,728		1,532,728			16
	C. General Administration											
17	Administrative	85,109			85,109		85,109		85,109			17
18	Directors Fees											18
19	Professional Services			351,039	351,039		351,039	(318,202)	32,837			19
20	Dues, Fees, Subscriptions & Promotions			2,632	2,632		2,632	679	3,311			20
21	Clerical & General Office Expenses	81,916	35,786	15,866	133,568		133,568	62,705	196,273			21
22	Employee Benefits & Payroll Taxes			418,852	418,852		418,852	7,954	426,806			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,533	7,533		7,533	26,491	34,024			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			131,045	131,045		131,045	99,071	230,116			26
27	Other (specify):*											27
28	TOTAL General Administration	167,025	35,786	926,967	1,129,778		1,129,778	(121,302)	1,008,476			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,652,219	248,508	1,455,546	3,356,273		3,356,273	(116,908)	3,239,365			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 Berkeley Nrsg & Rehab Center #0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,763	23,763		23,763	238,026	261,789			30
31	Amortization of Pre-Op. & Org.							1,145	1,145			31
32	Interest							112,615	112,615			32
33	Real Estate Taxes			163,425	163,425		163,425	203,827	367,252			33
34	Rent-Facility & Grounds			335,158	335,158		335,158	(316,378)	18,780			34
35	Rent-Equipment & Vehicles							264	264			35
36	Other (specify):*											36
37	**TOTAL Ownership**			522,346	522,346		522,346	239,499	761,845			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,052		52,052		52,052		52,052			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,111	161,111		161,111		161,111			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		52,052	161,111	213,163		213,163		213,163			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,652,219	300,560	2,139,003	4,091,782		4,091,782	122,591	4,214,373			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 Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	151,389	30		9
10	Interest and Other Investment Income	(7)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				24
25	Fund Raising, Advertising and Promotional	(10,716)	21		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	(2,617)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 138,049		$	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)	(15,458)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (15,458)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 122,591		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Berkeley Nrsg & Rehab Center

ID# 0050534

Report Period Beginning: 1/1/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending income	$ (2,617)	21	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
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,617)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Berkeley Nrsg & Rehab Center **#** 0050534 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	471	718	0	0	0	0	0	0	0	0	1,189	5
6	Maintenance	0	62	3,143	0	0	0	0	0	0	0	0	3,205	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	533	3,861	0	0	0	0	0	0	0	0	4,394	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	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(72,602)	(245,600)	0	0	0	0	0	0	0	0	(318,202)	19
20	Fees, Subscriptions & Promotions	0	104	575	0	0	0	0	0	0	0	0	679	20
21	Clerical & General Office Expenses	(13,333)	56,501	19,537	0	0	0	0	0	0	0	0	62,705	21
22	Employee Benefits & Payroll Taxes	0	7,954	0	0	0	0	0	0	0	0	0	7,954	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,221	24,270	0	0	0	0	0	0	0	0	26,491	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	197	98,874	0	0	0	0	0	0	0	0	99,071	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,333)	(5,625)	(102,344)	0	0	0	0	0	0	0	0	(121,302)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,333)	(5,092)	(98,483)	0	0	0	0	0	0	0	0	(116,908)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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	151,389	715	85,922	0	0	0	0	0	0	0	0	238,026	30
31	Amortization of Pre-Op. & Org.	0	0	1,145	0	0	0	0	0	0	0	0	1,145	31
32	Interest	(7)	0	112,622	0	0	0	0	0	0	0	0	112,615	32
33	Real Estate Taxes	0	0	203,827	0	0	0	0	0	0	0	0	203,827	33
34	Rent-Facility & Grounds	0	2,439	(318,817)	0	0	0	0	0	0	0	0	(316,378)	34
35	Rent-Equipment & Vehicles	0	264	0	0	0	0	0	0	0	0	0	264	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	151,382	3,418	84,699	0	0	0	0	0	0	0	0	239,499	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)	138,049	(1,674)	(13,784)	0	0	0	0	0	0	0	0	122,591	45

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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
Joseph Blisko	99			JB Healthcare	Skokie	Mgmt Co.
Nancy Blisko	1			Woodbine Realty	Oak Park	Realty Co.
				Senior Healthcare	Skokie	Mgmt Co.

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	5	Utilities	$	Senior Healthcare Management		$ 471	$ 471	1
2	V	6	Maintenance Supplies		Senior Healthcare Management		62	62	2
3	V	19	Professional Fees	73,000	Senior Healthcare Management		398	(72,602)	3
4	V	20	Lic, Dues & Subs		Senior Healthcare Management		104	104	4
5	V	21	Office Supplies		Senior Healthcare Management		1,093	1,093	5
6	V	21	Office Expense		Senior Healthcare Management		993	993	6
7	V	21	Office Wages		Senior Healthcare Management		54,415	54,415	7
8	V	22	Employee Benefits		Senior Healthcare Management		7,954	7,954	8
9	V	24	Travel & Seminar		Senior Healthcare Management		2,221	2,221	9
10	V	26	Insurance		Senior Healthcare Management		197	197	10
11	V	30	Depreciation		Senior Healthcare Management		715	715	11
12	V	34	Facility Rent		Senior Healthcare Management		2,439	2,439	12
13	V	35	Equipment Lease		Senior Healthcare Management		264	264	13
14	Total			$ 73,000			$ 71,326	$ * (1,674)	14

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

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	JB Healthcare		$ 718	$ 718	15
16	V	6	Professional Fees		JB Healthcare		160	160	16
17	V	19	Professional Fees	252,000	JB Healthcare		500	(251,500)	17
18	V	20	Dues & Subscriptions		JB Healthcare		325	325	18
19	V	21	Office Expense		JB Healthcare		19,537	19,537	19
20	V	22	Employee Benefits		JB Healthcare				20
21	V	24	Travel		JB Healthcare		24,270	24,270	21
22	V	34	Rent		JB Healthcare		16,342	16,342	22
23	V								23
24	V	6	Repairs & Maintenance		Woodbine Nursing Realty		2,983	2,983	24
25	V	19	Professional Fees		Woodbine Nursing Realty		5,900	5,900	25
26	V	20	Dues & Subscriptions		Woodbine Nursing Realty		250	250	26
27	V	21	Bank Service Charge		Woodbine Nursing Realty				27
28	V	26	Insurance		Woodbine Nursing Realty		98,874	98,874	28
29	V	30	Depreciation		Woodbine Nursing Realty		85,922	85,922	29
30	V	31	Amortization		Woodbine Nursing Realty		1,145	1,145	30
31	V	32	Interest		Woodbine Nursing Realty		112,622	112,622	31
32	V	33	Property Tax		Woodbine Nursing Realty		203,827	203,827	32
33	V	34	Rent	335,159	Woodbine Nursing Realty			(335,159)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 587,159			$ 573,375	$ * (13,784)	39

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

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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	TOTALS					$	$		$	25

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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**		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	HUD Mortgage		X	Mortgage	$37,689.00	8/24/12	$ 3,614,600	$ 3,327,181	9/1/2040	2.8500	$ 112,622	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$37,689.00		$ 3,614,600	$ 3,327,181			$ 112,622	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,614,600	$ 3,327,181			$ 112,622	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 16,500 Line # 32

*** 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 Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 201,804	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.)		$ 173,762	2
3. Under or (over) accrual (line 2 minus line 1).		$ (28,042)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 395,294	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.		$ 367,252	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	114,812	8
	2011	138,440	9
	2012	143,700	10
	2013	143,746	11
	2014	173,763	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Berkeley Nrsg & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050534

CONTACT PERSON REGARDING THIS REPORT Daniel S Gaafar

TELEPHONE 317-237-5500 FAX #: 317-237-5503

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-06-104-029-0000	6909 North Ave, Chicago, IL	$ 173,762.52	$ 173,762.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 173,762.52	$ 173,762.52

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 a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: N/A B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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 [X] (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).

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing		9/1/2009	$ 250,000	1
2					2
3	TOTALS			$ 250,000	3

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	72		2009		$ 1,050,000	$ 26,250	39	$ 26,923	$ 673	$ 113,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New Roofing System			9/23/2009	53,000	1,359	39	1,359		8,549	9
10	Cabinets/Carpet Removal & Plumbing Work			10/16/2009	1,872	48	39	48		302	10
11	New Acrylic Signs			9/21/2009	1,500	38	39	38		241	11
12	Cabling for Beds & Dining Room			3/15/2010	2,000	51	39	51		279	12
13	Bathroom Remodeling, Plumbing, and Materials			3/18/2010	2,588	66	39	66		361	13
14	Sprinkler System Repairs			8/27/2010	2,821	72	39	72		394	14
15	Sprinkler System Repairs			10/7/2010	4,579	117	39	117		640	15
16	Sprinkler System Repairs			10/21/2010	1,159	30	39	30		163	16
17	Sink and Drain Repairs			1/7/2010	6,475	166	39	166		906	17
18	Replacement Chiller Coil for Air Handler Unit			6/22/2010	4,125	106	39	106		578	18
19	Chiller Coil Installation			6/23/2010	1,583	41	39	41		223	19
20	Replacement Dryer Exhaust			7/13/2010	1,000	26	39	26		141	20
21	Replacement Fire Damper Motor			8/19/2010	1,556	40	39	40		218	21
22	Heating Systems Repair			11/1/2010	2,617	67	39	67		366	22
23	Awning			4/20/2010	2,500	64	39	64		349	23
24	Sprinkler System Repairs			7/16/2011	1,800	46	39	46		205	24
25	Plumbing Work			4/21/2011	3,250	83	39	83		370	25
26	New Flooring			7/19/2011	1,440	37	39	37		165	26
27	New Locks & Handles for Doors			4/4/2012	3,800	97	39	97		328	27
28	New Handrails & Repave Parking Lot			4/4/2012	11,455	294	39	294		992	28
29	Plumbing Work & Replace Floor Tiles			6/22/2012	15,000	385	39	385		1,299	29
30	Install Railings & Posts			6/22/2012	5,000	128	39	128		432	30
31	Outdoor cameras			10/22/2012	19,028	1,301	39	488	(813)	1,708	31
32	Relocate nurses call system			12/9/2012	3,414	234	39	88	(146)	2,532	32
33	Remodel dining room, nurses station, lobby & office			8/9/2012	309,000	7,923	39	7,923		22,245	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	* Install window, handrails, stone on walls in kitchen opening,	9/25/2013	$ 116,825	$ 2,996	39	$ 2,996	$	$ 6,866	37
38	door casings, wiring for time clock and lighting, exhaust fan								38
39	and doors in computer room, cove base, therapy room walls,								39
40	painting, chair rail, title, workstations, sink, fixtures, office								40
41	walls and painting, cove base, bathroom painting and tile,								41
42	sinks and toilet in nurses station, office, and bathroom								42
43									43
44	Main Hallway - celing tiles, handrail, carpet, cove base, paint,								44
45	door casing, vinyl sheets, laminate walls, floor prep, signage,								45
46	lighting, elecrical wiring, molding								46
47	Hospice Hallway - cabinets, countertops, carpet, cove base,								47
48	vent covers, door casings, paint, vinyl sheets, laminate walls,								48
49	corner guards, floor reducers, signage, arwork w/ security								49
50	hardware, electrical wiring for lights and signs	1/30/2014	155,500	3,987	39	3,987		7,808	50
51									51
52	Remove existing window and create door opening, patch brick,								52
53	prep foundation slab, install new door	3/5/2014	4,300	110	39	110		216	53
54									54
55	Flooring in resident rooms, cove base, wall coverings, painting,	5/15/2015	44,407	522	39	522		522	55
56	electrical, new closet dividers, ceiling tiles, plumbing in bathrooms								56
57	Tile and grout in bathrooms								57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,833,594	$ 46,684		$ 46,398	$ (286)	$ 173,148	70

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

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$ 1,076,957	$ 62,901	$ 215,391	$ 152,490	5 years	$ 761,681	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,076,957	$ 62,901	$ 215,391	$ 152,490		$ 761,681	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)	$ 3,160,551	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 109,585	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 261,789	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 152,204	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 934,829	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 Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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.

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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.

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	1,998	$ 110,698	$	1,998	$ 110,698	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		949	65,941		949	65,941	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,733	117,493		1,733	117,493	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				48,526		48,526	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Xray and Lab	39-2					3,526		3,526	12
13	Other (specify):									13
14	TOTAL			$	4,680	$ 294,132	$ 52,052	4,680	$ 346,184	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 Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	$ 377,994	$ 538,737	1
2	Cash-Patient Deposits	(378,635)	(378,635)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,194,095	1,194,095	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			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)**	$ 1,193,454	$ 1,354,197	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		250,000	13
14	Buildings, at Historical Cost		1,050,000	14
15	Leasehold Improvements, at Historical Cost	783,594	783,594	15
16	Equipment, at Historical Cost	101,957	1,076,957	16
17	Accumulated Depreciation (book methods)	(179,175)	(849,249)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,000,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(372,474)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Escrows & Refinance		113,289	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 706,376	$ 3,052,117	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,899,830	$ 4,406,314	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 327,570	$ 479,389	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	221,693	221,693	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 549,263	$ 701,082	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,418,466	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)**	$	$ 3,418,466	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 549,263	$ 4,119,548	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,350,567	$ 286,766	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,899,830	$ 4,406,314	48

*(See instructions.)

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 980,513	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 980,513	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	570,054	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	(200,000)	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)**	$ 370,054	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,350,567	24	*

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

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$ 4,562,139	1
2	Discounts and Allowances for all Levels	(355,726)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,206,413	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	417,495	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 417,495	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	27,778	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,186	19
20	Radiology and X-Ray	1,340	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 35,304	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	2,617	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,617	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,661,836	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	693,767	31
32	Health Care	1,532,728	32
33	General Administration	1,129,778	33
	B. Capital Expense		
34	Ownership	522,346	34
	C. Ancillary Expense		
35	Special Cost Centers	52,052	35
36	Provider Participation Fee	161,111	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,091,782	40
41	**Income before Income Taxes (line 30 minus line 40)****	570,054	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 570,054	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,821,725	44
45	Private Pay - Net Inpatient Revenue	214,293	45
46	Medicare - Net Inpatient Revenue	942,010	46
47	Other-(specify) Commercial	228,385	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,206,413	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	2,070	2,244	$ 87,091	$ 38.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,060	5,275	157,650	29.89	3
4	Licensed Practical Nurses	14,815	15,903	407,750	25.64	4
5	CNAs & Orderlies	32,379	34,191	343,924	10.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,701	5,035	57,701	11.46	10
11	Social Service Workers	2,098	2,276	35,603	15.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,346	15,545	174,327	11.21	15
16	Dishwashers					16
17	Maintenance Workers	1,856	2,049	31,903	15.57	17
18	Housekeepers	8,747	9,378	82,436	8.79	18
19	Laundry	3,448	3,869	37,472	9.69	19
20	Administrator	2,058	2,166	85,109	39.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,616	7,189	81,916	11.39	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	205	235	2,581	10.98	31
32	Other Health C: MDS	1,828	1,992	66,756	33.51	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	100,227	107,347	$ 1,652,219 *	$ 15.39	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	159	$ 5,566	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	7	240	10-3	38
39	Pharmacist Consultant	118	5,910	15-3	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	81	2,837	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	365	$ 14,553		49

C. CONTRACT NURSES

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

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theodora Schild	Administrator		$ 85,109
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,109

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Senior Healthcare	Mgmt Co.	$ 73,000
Bradley Associates	Accounting	10,808
Alan Irni	Accounting	1,500
Kitch Law Firm	Legal	2,781
Summers Compton Wells	Legal	1,083
Skidelsky & Associates	Legal	220
Massimino	Legal	2,000
Lake Forest B&T	Legal	555
Lake Forest B&T	Legal	5,000
JB Healthcare	Mgmt Co	252,000
O'Halleron	Professional Fees	2,092
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 351,039

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 114,670
Unemployment Compensation Insurance	40,864
FICA Taxes	146,765
Employee Health Insurance	112,661
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	11,191
Employee expense	(1,056)
Continuing Education	1,711
TOTAL (agree to Schedule V, line 22, col.8)	$ 426,806

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Secretary of State	250
LTC Renewal	1,990
City registration fees	293
Amazon Prime	99
Home offce licenses & subs	679
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,311

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	11,719
Mileage	8,270
Home office travel and meals	14,035
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 34,024

**See instructions.

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/15 Ending: 12/31/15

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(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 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,297** Line **10-2**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **161,111**
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? **N/A**

(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? **N/A** 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. $ **None** Has any meal income been offset against related costs? **N/A** 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? **100%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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 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.