

		FOR BHF USE				

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

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>0026195</u></p> <p>Facility Name: <u>Lieberman Ctr for Hlth & Reh</u></p> <p>Address: <u>9700 Gross Point Rd</u> <u>Skokie</u> <u>60076</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>847 674-7210</u> Fax # <u>847 674-6366</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>06/18/1981</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael Geraghty</u> Telephone Number: <u>773 508-4465</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p align="center"> I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2014</u> to <u>06/30/2015</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 align="center"> Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. </p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Ronald C. Benner</u> (Title) <u>Executive Director</u> </td> </tr> <tr> <td style="width:25%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # () </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Ronald C. Benner</u> (Title) <u>Executive Director</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Ronald C. Benner</u> (Title) <u>Executive Director</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()							

Facility Name & ID Number Lieberman Ctr for Hlth & Reh

0026195 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	240	Skilled (SNF)	240	87,600	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	240	TOTALS	240	87,600	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	47,452	15,459	13,347	76,258	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,452	15,459	13,347	76,258	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.05%

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)

meals on wheels

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 09/20/1981

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/20/1981 NO

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

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2015 Fiscal Year: 06/30/2015

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

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

	Operating Expenses	Costs 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
	A. General Services										
1	Dietary	687,305		1,431,827	2,119,132		2,119,132	(40,725)	2,078,407		1
2	Food Purchase										2
3	Housekeeping	589,573	35,559	150,460	775,592		775,592		775,592		3
4	Laundry	28,861	71,018	330	100,209		100,209		100,209		4
5	Heat and Other Utilities			403,810	403,810		403,810		403,810		5
6	Maintenance	159,503	6,481	431,612	597,596		597,596		597,596		6
7	Other (specify):* Schedule 3_4A			178,078	178,078		178,078		178,078		7
8	TOTAL General Services	1,465,242	113,058	2,596,117	4,174,417		4,174,417	(40,725)	4,133,692		8
	B. Health Care and Programs										
9	Medical Director					63,000	63,000		63,000		9
10	Nursing and Medical Records	7,244,400	542,278	111,637	7,898,315	4,800	7,903,115	(664)	7,902,451		10
10a	Therapy			1,696,989	1,696,989		1,696,989		1,696,989		10a
11	Activities	149,643	16,208	1,500	167,351		167,351		167,351		11
12	Social Services	267,314		41	267,355		267,355		267,355		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	7,661,357	558,486	1,810,167	10,030,010	67,800	10,097,810	(664)	10,097,146		16
	C. General Administration										
17	Administrative	224,299		60,322	284,621		284,621	(89,859)	194,762		17
18	Directors Fees										18
19	Professional Services			301,806	301,806	(83,967)	217,839	(24,168)	193,671		19
20	Dues, Fees, Subscriptions & Promotions			59,301	59,301	373	59,674		59,674		20
21	Clerical & General Office Expenses	456,385	33,541	47,349	537,275		537,275		537,275		21
22	Employee Benefits & Payroll Taxes			2,908,353	2,908,353		2,908,353	(29,805)	2,878,548		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,029	6,029	(457)	5,572		5,572		24
25	Other Admin. Staff Transportation			625	625	84	709		709		25
26	Insurance-Prop.Liab.Malpractice			244,235	244,235	16,167	260,402	(15,417)	244,985		26
27	Other (specify):* Schedule 3_4A	49,639		399,739	449,378		449,378	1,155,695	1,605,073		27
28	TOTAL General Administration	730,323	33,541	4,027,759	4,791,623	(67,800)	4,723,823	996,446	5,720,269		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,856,922	705,085	8,434,043	18,996,050		18,996,050	955,057	19,951,107		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.

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			1,025,836	1,025,836		1,025,836	(5,960)	1,019,876		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			409,078	409,078		409,078		409,078		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			285,866	285,866	(1,564)	284,302		284,302		35
36	Other (specify):*			200,818	200,818		200,818		200,818		36
37	TOTAL Ownership			1,921,598	1,921,598	(1,564)	1,920,034	(5,960)	1,914,074		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation					1,564	1,564		1,564		38
39	Ancillary Service Centers		623,529	84,333	707,862		707,862	(84,332)	623,530		39
40	Barber and Beauty Shops		1,815	25,351	27,166		27,166		27,166		40
41	Coffee and Gift Shops		5,064		5,064		5,064	(2,826)	2,238		41
42	Provider Participation Fee			514,605	514,605		514,605		514,605		42
43	Other (specify):* disposable fixed assets			22,285	22,285		22,285	(22,285)			43
44	TOTAL Special Cost Centers		630,408	646,574	1,276,982	1,564	1,278,546	(109,443)	1,169,103		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,856,922	1,335,493	11,002,215	22,194,630		22,194,630	839,654	23,034,284		45

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

Lieberman Geriatric Health Centre
Provider #0026195
07/01/14 - 06/30/15

Schedule 3/4A

V - Operating Expenses

	Description	Amount
Line 9	To reclassify medical director expense	63,000
Line 19	To reclassify medical director expense	(63,000)
Line 26	To reclassify surety bond	750
Line 19	To reclassify surety bond	(750)
Line 26	To reclassify professional liability insurance	15,417
Line 19	To reclassify professional liability insurance	(15,417)
Line 38	To reclassify Medigar	1,564
Line 35	To reclassify Medigar	(1,564)
Line 25	To reclassify travel expense (mileage reimbursement)	84
Line 24	To reclassify travel expense (mileage reimbursement)	(84)
Line 24	To reclassify publications	373
Line 20	To reclassify publications	(373)
Line 10	To reclassify nephrology consultant	4,800
Line 19	To reclassify nephrology consultant	(4,800)
Line 7	Security service	127,462
	Waste removal	50,616
		<u>178,078</u>
Line 27-1	Marketing and Outreach Manager	49,639
Line 27-3	Insurance Claim Deductible	25,000
Line 27-3	Bad Debt Expense	374,739
		<u>449,378</u>

FOR LINES 1 THRU 28 AND 31 THRU 33, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINES 29 OR 35 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS
 Facility Name & ID Number Lieberman Ctr for Hlth & Reh # 0026195 Report Period Beginning: 07/01/2014 Ending: 06/30/2015 Page 5

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	(27,002)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(13,723)	1		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	(15,417)	26		23
24	Bad Debt	(374,739)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PG5A	1,270,535			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 839,654		\$	30

BHF USE ONLY							
48		49		50		51	

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 839,654		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

Lieberman Ctr for Hlth & Reh

ID# 0026195

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	entertainment expense	\$ (7,331)	17	1
2	entertainment expense	(664)	10	2
3	marketing expense/business development	(53,285)	17	3
4	fun committee expense	294	17	4
5	merchandise purchases	(2,237)	17	5
6	lobbying fees	(18,504)	19	6
7	to add back direct costs for support services	1,580,073	27	7
8	vending expense	(2,826)	41	8
9	building depreciation per ledger vs. Medicaid report	(4,709)	30	9
10	f&f depreciaton per ledger vs. Medicaid report	(1,251)	30	10
11	accrued vacation pay	(29,805)	22	11
12	rooftop antenna revenue	(27,300)	17	12
13	fixed asset disposals	(22,285)	43	13
14	non-allowable legal fees	(5,664)	19	14
15	marketing salaries	(49,639)	27	15
16	Medicare lab expense	(60,099)	39	16
17	Medicare radiology expense	(15,588)	39	17
18	Medicare echoardiogram/EKG	(2,552)	39	18
19	Medicare perivascular lab	(410)	39	19
20	Medicare PET scan	(1,286)	39	20
21	Medicare blood draw/iron IV	(394)	39	21
22	Medicare ST eval	(1,380)	39	22
23	Medicare OT eval	(172)	39	23
24	Medicare bood admin/storage	(483)	39	24
25	Medicare clinic	(295)	39	25
26	Medicare nuclear med/radiopharmacolgy	(1,049)	39	26
27	Medicare drugs	(587)	39	27
28	Medicare pathology lab	(37)	39	28
29				29
30				30
31				31
32				32
33				33

Sch V	Adj. Summary
Line 1	(40,725)
Line 2	0
Line 3	0
Line 4	0
Line 5	0
Line 6	0
Line 7	0
Line 8	(40,725)
Line 9	0
Line 10	(664)
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	(664)
Line 17	(89,859)
Line 18	0
Line 19	(24,168)
Line 20	0
Line 21	0
Line 22	(29,805)
Line 23	0
Line 24	0
Line 25	0
Line 26	(15,417)
Line 27	1,155,695
Line 28	996,446
Line 29	955,057
Line 30	(5,960)
Line 31	0

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	1,270,535	49

Line 32	0
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(5,960)
Line 38	0
Line 39	(84,332)
Line 40	0
Line 41	(2,826)
Line 42	0
Line 43	(22,285)
Line 44	(109,443)
Line 45	839,654

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lieberman Ctr for Hlth & Reh

0026195

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(40,725)	0	0	0	0	0	0	0	0	0	0	(40,725)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(40,725)	0	0	0	0	0	0	0	0	0	0	(40,725)	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	(664)	0	0	0	0	0	0	0	0	0	0	(664)	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	(664)	0	0	0	0	0	0	0	0	0	0	(664)	16
	C. General Administration													
17	Administrative	(89,859)	0	0	0	0	0	0	0	0	0	0	(89,859)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(24,168)	0	0	0	0	0	0	0	0	0	0	(24,168)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(29,805)	0	0	0	0	0	0	0	0	0	0	(29,805)	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	(15,417)	0	0	0	0	0	0	0	0	0	0	(15,417)	26
27	Other (specify):*	1,155,695	0	0	0	0	0	0	0	0	0	0	1,155,695	27
28	TOTAL General Administration	996,446	0	0	0	0	0	0	0	0	0	0	996,446	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	955,057	0	0	0	0	0	0	0	0	0	0	955,057	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

Lieberman Ctr for Hlth & Reh

0026195

Report Period Beginning:

07/01/2014 Ending:

06/30/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(5,960)	0	0	0	0	0	0	0	0	0	0	(5,960) 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	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(5,960)	0	0	0	0	0	0	0	0	0	0	(5,960) 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	(84,332)	0	0	0	0	0	0	0	0	0	0	(84,332) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	(2,826)	0	0	0	0	0	0	0	0	0	0	(2,826) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(22,285)	0	0	0	0	0	0	0	0	0	0	(22,285) 43
44	TOTAL Special Cost Centers	(109,443)	0	0	0	0	0	0	0	0	0	0	(109,443) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	839,654	0	0	0	0	0	0	0	0	0	0	839,654 45

Lieberman Geriatric Health Center
07/01/14 - 06/30/15
Schedule of Adjustments
Summary C

Description	Department	Amount
non-patient meals	Dietary	(27,002)
group purchasing rebates	Administration	(\$13,723)
non-care related interest	Administration	
malpractice insurance for individuals	Administration	(15,417)
bad debt	Administration	(374,739)
entertainment expense	Administration	(7,331)
entertainment expense	Administration	(664)
marketing expense/business development	Administration	(53,285)
fun committee expense	Administration	294
merchandise purchases	Administration	(2,237)
lobbying fees	Administration	(18,504)
to add back direct costs for support services	Depreciation	1,580,073
vending expense	Depreciation	(2,826)
building depreciation per ledger vs. Medicaid report	Administration	(4,709)
f&f depreciaton per ledger vs. Medicaid report	Administration	(1,251)
accrued vacation pay	Administration	(29,805)
rooftop antenna revenue	Administration	(27,300)
fixed asset disposals	Administration	(22,285)
non-allowable legal fees	Administration	(5,664)
marketing salaries	Nursing	(49,639)
Medicare lab expense	Nursing	(60,099)
Medicare radiology expense	Nursing	(15,588)
Medicare echoardiogram/EKG	Nursing	(2,552)
Medicare perivascular lab	Nursing	(410)
Medicare PET scan	Nursing	(1,286)
Medicare blood draw/iron IV	Nursing	(394)
Medicare ST eval	Nursing	(1,380)
Medicare OT eval	Nursing	(172)
Medicare bood admin/storage	Nursing	(483)
Medicare clinic	Nursing	(295)
Medicare nuclear med/radiopharmacolgy	Nursing	(1,049)
Medicare drugs	Nursing	(587)
Medicare pathology lab	Nursing	(37)

\$839,654

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
n/a						

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		\$			\$	\$	1
2	V							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		\$			\$	\$ *	14

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

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

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	n/a								\$	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 Lieberman Ctr for Hlth & Reh

0026195 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

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

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

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

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	27	Admin, Finance, Volunteers, Info	Accumulated Costs	61,577,454	15	\$ 3,545,931	\$ 3,545,931	21,879,923	\$ 1,259,953	1
2	27	Admin, Finance, Volunteers, Info	Accumulated Costs	61,577,454	15	900,924	21,879,923	320,120		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					\$ 4,446,855	\$ 3,545,931		\$ 1,580,073	25

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										
										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		X	2005 Bond	varies	01/19/05	\$ 8,150,000	\$ 6,150,000	2025	varies	\$ 278,436	1								
2		X	2008 bond allocation	varies	08/13/08	2,217,600	1,794,730	2026	varies	87,763	2								
3		X	capital improvements	\$8,333.33	07/20/11	2,000,000	1,691,667	08/31/16	1.2500	35,547	3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$8,333.33		\$ 12,367,600	\$ 9,636,397			\$ 401,747	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 12,367,600	\$ 9,636,397			\$ 401,747	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line # n/a

* 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 2014 report.	\$	n/a		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.)	\$	n/a		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	n/a		3
4.	Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	n/a		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.)	\$	n/a		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.)	\$	n/a		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	n/a		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2010	_____	8	
		2011	_____	9	
		2012	_____	10	
		2013	_____	11	
		2014	_____	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2014 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2014 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2014.

Please complete the Real Estate Tax Statement below and include it in the 2015 cost report along with a copy of your 2014 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lieberman Ctr for Hlth & Reh COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026195

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	_____	_____	\$ n/a	\$ _____
2.	_____	_____	\$ _____	\$ _____

3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <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 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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 150,487 B. General Construction Type: Exterior brick Frame concrete, metal Number of Stories 7

C. Does the Operating Entity? (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? (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).

n/a

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>facility</u>	<u>216,480</u>	<u>1980</u>	<u>\$ 809,873</u>	1
2					2
3	TOTALS	216,480		\$ 809,873	3

Facility Name & ID Number Lieberman Ctr for Hlth & Reh# 0026195

Report Period Beginning:

07/01/2014 Ending: 06/30/2015**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	240		1981	1981	\$ 10,023,348	\$ 250,585	40	\$ 250,585		\$ 8,457,224	4
5			1983		32,224	805	40	805		26,164	5
6			1984		7,755	194	40	194		6,111	6
7			1986		29,583	739	40	739		21,062	7
8			1987		19,886	497	40	497		14,175	8
	Improvement Type**										
9		Land Improvements		1981	96,365					96,365	9
10		Land Improvements		1983	54,161					54,161	10
11		Land Improvements		1985	3,575					3,575	11
12		Land Improvements		1987	78,564					78,564	12
13		Land Improvements		1988	7,394					7,394	13
14		Land Improvements		1989	19,724					19,724	14
15		Capital		1990	26,136					26,136	15
16		Capital		1991	47,606					47,606	16
17		Capital		1992	230,717					230,717	17
18		Capital		1993	15,514					15,514	18
19		Capital		1994	53,935					53,935	19
20		Capital		1995	2,990					2,993	20
21		Capital		1996	4,047,575					4,047,575	21
22		Capital		1997	101,705					101,705	22
23		Capital		1998	163,173					163,174	23
24		Capital		1999	1,217,837					1,217,837	24
25		Capital		2000	222,449					222,449	25
26		Capital		2001	315,065					315,066	26
27		Capital		2002	135,808					135,817	27
28		Capital		2003	528,958					523,057	28
29		Capital		2004	564,401					564,401	29
30		Capital		2005	741,195	74,120	10	74,120		721,758	30
31		Capital		2006	145,768	14,577	10	14,577		138,056	31
32		Capital		2007	172,613	17,261	10	17,261		141,974	32
33		Capital		2008	93,672	9,367	10	9,367		63,455	33
34		Capital		2009	177,099	17,710	10	17,710		106,830	34
35		Capital		2009	54,585	2,729	20	2,729		18,952	35
36		Capital		2010	80,735	8,074	10	8,074		44,312	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 Lieberman Ctr for Hlth & Reh# 0026195

Report Period Beginning:

07/01/2014 Ending: 06/30/2015

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	Capital	2010	\$ 121,308	\$ 6,065	20	\$ 6,065	\$	\$ 39,716	37
38	Capital	2011	192,049	19,205	10	19,205		77,606	38
39	Capital	2011	1,202,505	60,125	20	60,125		253,653	39
40	Fan switch repl-cooling/heating unit/Mammoth MUA controller	2012	4,256	426	10	426		1,313	40
41									41
42	Major repairs to Tausen blast chiller	2012	3,354	335	10	335		1,033	42
43	Install of dedicated circuits to A wing	2012	5,751	575	10	575		1,773	43
44	1st, 2nd & 4th Floor Renovation - architect	2012	6,094	305	20	305		966	44
45	Café door controller	2012	3,870	387	10	387		1,355	45
46	1st, 2nd & 4th Floor Renovation-labor and install of corner guards	2012	4,736	237	20	237		829	46
47									47
48	HVAC fan coils	2012	9,902	990	10	990		3,465	48
49	HVAC circulating pump motor rebuild	2012	3,017	302	10	302		1,057	49
50	HVAC boiler riser pump	2012	5,095	510	10	510		1,785	50
51	HVAC pump rebuild	2012	4,683	468	10	468		1,599	51
52	McQuay compressor replacement	2012	14,640	1,464	10	1,464		4,514	52
53	Resident room convector replacement project	2012	7,221	722	10	722		2,407	53
54	Admin office renovation-architect	2012	4,233	212	20	212		636	54
55	Fire alarm panel ugrade	2012	16,435	1,644	10	1,644		5,480	55
56	Cooling tower frequency drive	2012	7,935	794	10	794		2,713	56
57	Landscape achitecture project	2012	15,880	1,588	10	1,588		5,293	57
58	Landscape achitecture project	2012	9,752	650	15	650		1,950	58
59	Restoration of riser unit	2012	18,870	1,887	10	1,887		5,661	59
60	Replacement of MUA compressor	2012	12,775	1,278	10	1,278		3,834	60
61	Remodel admin offices-demolition,carpet,								61
62	furniture, architect fees	2012	22,472	2,247	10	2,247		7,486	62
63	Remodel admin offices - patch and paint offices	2012	6,900	1,380	5	1,380		3,795	63
64	Oxygen room doors replacement	2012	2,610	131	20	131		360	64
65	Guardrail/handrail modifications	2012	7,200	360	20	360		960	65
66	Replaced water coils in 2 room heating units	2013	7,404	740	10	740		1,850	66
67	3rd, 6th and 7th floor renovation - architect fee	2013	98,931	9,893	10	9,893		22,259	67
68	3rd, 6th and 7th floor renovation - IDPH plan review	2013	9,600	960	10	960		2,000	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 21,341,592	\$ 512,536		\$ 512,536	\$	\$ 18,145,186	70

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

Facility Name & ID Number Lieberman Ctr for Hlth & Reh# 0026195

Report Period Beginning:

07/01/2014 Ending: 06/30/2015

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 21,341,592	\$ 512,536		\$ 512,536	\$	\$ 18,145,186	1
2	Install 2 boilers and roof restoration	2013	575,629	28,781	20	28,781		64,757	2
3	3rd floor renovation - install carpet tiles	2013	9,384	938	10	938		2,189	3
4	Fire protection sprinkler installation	2013	144,982	14,498	10	14,498		31,412	4
5	Resident room convector units installed	2013	40,000	4,000	10	4,000		8,000	5
6	Fire safety evaluation survey(part of fire protection sprinkler project)	2013	9,620	962	10	962		2,245	6
7	Upgrade kitchen ductwork/lighting	2013	115,280	11,528	10	11,528		24,017	7
8	Plumbing, excavation for stack in bread room	2013	20,195	2,020	10	2,020		4,545	8
9	Replace laundry hot water tank	2013	19,760	1,976	10	1,976		4,940	9
10	Kitchen wall repair (part of kitchen renovation)	2013	3,448	345	10	345		747	10
11	Landscape architecture project	2013	330,739	22,049	15	22,049		55,123	11
12	Parking lot renovation	2013	15,464	1,031	15	1,031		2,406	12
13	Installed burner assembly and ignitor in hot water heater	2013	2,545	254	10	254		529	13
14	New motors and parts elevator room cooling system	2013	3,413	341	10	341		710	14
15	New air compressor in mechanical room unit	2013	2,689	269	10	269		560	15
16	Rehab generator emergency shutdown with new circuits	2013	2,575	258	10	258		537	16
17	Install new sewage ejector pump	2013	5,891	589	10	589		1,227	17
18									18
19	Purchased/installed vanity fixtures	2013	42,768	4,277	10	4,277		8,910	19
20	6th and 7th floor renovation architect fee	2013	4,127	413	10	413		791	20
21	Replace two boilers-part of boiler and roof restoration project	2013	573,392	28,670	20	28,670		54,950	21
22	Part of fire protection sprinkler installation	2013	39,292	3,929	10	3,929		7,531	22
23	Installation of sprinklers - elevator room	2013	12,000	1,200	10	1,200		2,000	23
24	Resident room thermostats	2013	6,440	322	20	322		590	24
25	Installation of 4 soft starts on elevators #2 and #3	2013	10,851	1,085	10	1,085		1,989	25
26	Installation of fire system tampers and flows	2013	19,924	1,992	10	1,992		3,154	26
27	Landscape architecture project - completion	2013	72,914	7,291	10	7,291		13,975	27
28	Kitchen wall repair (part of kitchen renovation)-final pmt	2013	3,448	345	10	345		374	28
29	Installation kidney dialysis unit plumbing	2014	35,220	3,522	10	3,522		5,283	29
30	Installation of keypad entry locks	2014	3,362	336	10	336		364	30
31	Installation of flooring in four elevators	2014	3,760	376	10	376		407	31
32	Replacement of 2nd floor 2" pipe	2014	3,700	370	10	370		401	32
33	Replacement of hot water riser	2014	3,000	300	10	300		325	33
34	TOTAL (lines 1 thru 33)		\$ 23,477,404	\$ 656,804		\$ 656,804	\$	\$ 18,450,174	34

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

Facility Name & ID Number Lieberman Ctr for Hlth & Reh

0026195

Report Period Beginning:

07/01/2014 Ending: 06/30/2015

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 23,477,404	\$ 656,804		\$ 656,804	\$	\$ 18,450,174	1
2	Replacement of boiler & pressure pump lect switching apparatus	2014	3,587	359	10	359		389	2
3	Modifications to two tub rooms, including door alterations	2014	27,605	2,761	10	2,761		4,141	3
4	Phase II 3,5,6,7 floor renovation architect fees	2014	25,562	2,556	10	2,556		3,834	4
5	Phase II -removal of carpet from 3rd floor rooms	2013	4,000	400	10	400		633	5
6	Phase II 3,5,6,7 floor renovation permit fee	2014	21,600	2,160	10	2,160		2,520	6
7	Phase II 3,5,6,7 floor renovation removal of asbestos flooring; air m	2014	13,600	1,360	10	1,360		1,473	7
8	2nd floor empl locker room renovation - architect fees	2014	4,040	404	10	404		438	8
9	Installation of floor shut off valves	2014	7,500	750	10	750		813	9
10	Resident room thermostats	2014	6,440	644	10	644		1,181	10
11	Installation of horizontal hot water shut off valves-down pmt	2014	3,000	300	10	300		325	11
12	Installation of boiler and hot water return	2014	3,296	110	20	110		110	12
13	Installation of closers for smoke & fire barrier doors	2015	4,528	38	20	38		38	13
14	Replacement of pump seal assy for penthouse chilled water pump	2015	3,079	26	20	26		26	14
15	Installation of horizontal hot water shut off valves-final pmt	2015	3,000	25	20	25		25	15
16	Installation of smoke/carbon monoxide detectors	2015	6,488	27	20	27		27	16
17	Kitchen floor refinishing-dairy /meat dish rooms	2015	17,646	441	20	441		441	17
18	Installation MUA-D heater heat exchanger	2015	5,093	42	20	42		42	18
19	Replaced diaphragm/hot surface ignitor on hot water heater	2015	3,342	28	20	28		28	19
20	Replaced chiller #2 low pressure control, motor & fan blade	2015	5,505	23	20	23		23	20
21	Room 778 fan coil replacement	2015	2,692	11	20	11		11	21
22	Sprinkler installation, final payment	2014	4,831	161	20	161		161	22
23	Phase II 3,5,6,7 floor renovation architect fees	2015	33,726	843	20	843		843	23
24	Phase II 3,5,6,7 floor renovation contractor fees	2015	1,534,739	31,974	20	31,974		31,974	24
25	Phase II 3,5,6,7 floor air monitoring	2015	14,700	306	20	306		306	25
26	Phase II 3,5,6,7 floor asbestos abatement	2015	64,967	1,353	20	1,353		1,353	26
27	Phase II 3,5,6,7 floor storage fees	2015	9,732	203	20	203		190	27
28	Phase II 3,5,6,7 floor replacement of balconies	2015	31,788	132	20	132		132	28
29	Phase II 3,5,6,7 floor installation of fire dampers	2015	37,363	311	20	311		311	29
30	Phase II 3,5,6,7 floor relocation of sprinklers	2015	3,045	76	20	76		76	30
31	Phase II 3,5,6,7 floor relocation of nurse call consoles	2015	7,445	372	10	372		372	31
32	Plumbing infrastructure-shut off valves	2015	22,940	191	20	191		191	32
33	Plumbing infrastructure-sanitary sewer rerouting	2014	8,150	272	20	272		272	33
34	TOTAL (lines 1 thru 33)		\$ 25,422,431	\$ 705,463		\$ 705,463	\$	\$ 18,502,873	34

**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	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 25,422,431	\$ 705,463		\$ 705,463		\$ 18,502,873		1
2	Plumbing infrastructure-dialysis room RPZ valves	2015 5,825	121	20	121		121		2
3	Plumbing infrastructure-janitor closets RPZ valves	2015 3,500	73	20	73		73		3
4	Plumbing infrastructure-kitchen RPZ valves	2015 8,488	106	20	106		106		4
5	Plumbing infrastructure-excavation under dishwashers	2015 14,765	246	20	246		246		5
6	Replace CPU, door restrictor, door drive	2015 12,541	105	20	105		105		6
7	Relocate conduits/replace wiring under dishwasher	2015 14,686	306	20	306		306		7
8	adj to agree to book depreciation		4,709			(4,709)			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)	\$ 25,482,235	\$ 711,129		\$ 706,420	\$ (4,709)	\$ 18,503,830		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	\$ 5,241,701	\$ 314,299	\$ 314,299	\$		\$ 3,699,423	71
72	Current Year Purchases	523,074	408	(843)	(1,251)		408	72
73	Fully Depreciated Assets							73
74	Disposal of Assets	(1,724,454)						74
75	TOTALS	\$ 4,040,322	\$ 314,707	\$ 313,456	\$ (1,251)		\$ 3,699,831	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)	\$ 30,332,430	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,025,836	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,019,876	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,960)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 22,203,661	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 Lieberman Ctr for Hlth & Reh

0026195

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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:				\$ <u>n/a</u>			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: _____

*

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: \$ 266,287

Description: See Schedule 14A

(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	<u>n/a</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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 \$ _____

* 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.

Lieberman Geriatric Health Centre
Provider #0026195
07/01/14 - 06/30/15

Schedule 14A

Section B

	Description	Amount
Line 16 Rental Amount for Moveable Equipment	Tableware	27,884
	Wound therapy	27,218
	Copier/postage meter	2,316
	Beds/mattresses/chairs/O2 concentrators	208,149
	Online Service	720
	Total	<u>266,287</u>

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		3	4
		1	2		
		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	10(3)	hrs	\$	9,537	\$ 641,161	\$	9,537	\$ 641,161	1
2	Licensed Speech and Language Development Therapist	10(3)	hrs		2,373	170,854		2,373	170,854	2
3	Licensed Recreational Therapist	19(3)	hrs		12	40,000		12	40,000	3
4	Licensed Physical Therapist	10(3)	hrs		12,931	884,974		12,931	884,974	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				653,528		653,528	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			\$	24,853	\$ 1,736,989	\$ 653,528	24,853	\$ 2,390,517	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 Lieberman Ctr for Hlth & Reh # 0026195 Report Period Beginning: 07/01/2014 Ending: 06/30/2015
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2015 (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	\$ 23,194	\$ 23,194	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (201,066))	4,526,812	4,526,812	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	112,873	112,873	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Schedule 17A</u>	789,535	789,535	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,452,414	\$ 5,452,414	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	809,873	809,873	13
14	Buildings, at Historical Cost	10,112,795	10,112,795	14
15	Leasehold Improvements, at Historical Cost	9,292,125	9,292,125	15
16	Equipment, at Historical Cost	4,058,290	4,058,290	16
17	Accumulated Depreciation (book methods)	(14,467,890)	(22,203,661)	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)	\$ 9,805,192	\$ 2,069,421	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,257,606	\$ 7,521,836	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,067,962	\$ 1,067,962	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,102	18,102	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,207,598	1,207,598	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	25,850	25,850	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Schedule 17A</u>	13,170,150	13,170,150	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 15,489,661	\$ 15,489,661	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	9,821,295	9,821,295	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Loans payable - Aramark</u>	21,438	21,438	43
44	<u>Bond swap contract - 2012</u>	941,404	941,404	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,784,136	\$ 10,784,136	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 26,273,797	\$ 26,273,797	46
47	TOTAL EQUITY (page 18, line 24)	\$ (11,016,191)	\$ (11,016,191)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,257,606	\$ 15,257,606	48

*(See instructions.)

Schedule 17A

XV - Balance Sheet: Line 9 - Current Assets - Other (specify):

Description	Operating	After Consolidation
Cash - resident security deposits	376,461	376,461
Deferred financing fees	42,490	42,490
Wells Fargo bond fund	260,403	260,403
Insurance claim receivable	100,000	100,000
Investments - board designated	10,182	10,182
	<u>789,535</u>	<u>789,535</u>

XV - Balance Sheet: Line 36 - Other Current Liabilities (specify):

Description	Operating	After Consolidation
Tenant security deposits	386,761	386,761
Accounts receivable credit balances	265,856	265,856
Other current liabilities	2,607	2,607
Accrued expenses	161,834	161,834
Intercompany liabilities	12,039,841	12,039,841
Other payables - insurance claim	313,250	313,250
	<u>13,170,150</u>	<u>13,170,150</u>

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (9,424,876)	1
2	Restatements (describe):		2
3	audit adjusting entry	(38,998)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (9,463,874)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,552,317)	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	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,552,317)	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)	\$ (11,016,191)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lieberman Ctr for Hlth & Reh

0026195

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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	\$ 19,049,407	1
2	Discounts and Allowances for all Levels	(102,996)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,946,411	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	571,910	6
7	Oxygen	1,371	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 573,281	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	4,353	12
13	Barber and Beauty Care	27,649	13
14	Non-Patient Meals	23,190	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	1,916	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 57,107	23
D. Non-Operating Revenue			
24	Contributions	530,508	24
25	Interest and Other Investment Income***	4,869	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 535,377	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Schedule 19A</u>	530,138	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 530,138	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 20,642,314	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	4,174,417	31
32	Health Care	10,030,010	32
33	General Administration	4,791,623	33
B. Capital Expense			
34	Ownership	1,921,598	34
C. Ancillary Expense			
35	Special Cost Centers	762,377	35
36	Provider Participation Fee	514,605	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,194,630	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,552,317)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,552,317)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,464,132	44
45	Private Pay - Net Inpatient Revenue	4,816,578	45
46	Medicare - Net Inpatient Revenue	6,517,788	46
47	Other-(specify) <u>Hospice</u>	12,757	47
48	Other-(specify) <u>Supplies</u>	135,156	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 18,946,411	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

Lieberman Geriatric Health Centre
Provider #0026195
07/01/14 - 06/30/15

Schedule 19A

XVIII - INCOME STATEMENT - Line 28 - Other Revenue (specify):

Description	Amount	
Group purchasing rebates	13,723	offset on Schedule V
Rooftop antenna revenue	27,300	offset on Schedule V
Grant Income	89,821	
Bond swap contract income (expense)	(941,404)	
Other income for maintenance operations and capital	1,340,697	
Total to Line 28	<u>530,138</u>	

Facility Name & ID Number Lieberman Ctr for Hlth & Reh
 XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
 (This schedule must cover the entire reporting period.)

0026195

Report Period Beginning: 07/01/2014 Ending: 06/30/2015

	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	1,933	2,086	\$ 110,274	\$ 52.86	1
2	Assistant Director of Nursing	2,892	3,361	137,196	40.82	2
3	Registered Nurses	66,516	72,688	2,644,993	36.39	3
4	Licensed Practical Nurses	15,737	17,278	499,762	28.92	4
5	CNAs & Orderlies	208,364	223,579	3,050,937	13.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,726	2,086	45,223	21.68	9
10	Activity Assistants	5,899	6,626	104,421	15.76	10
11	Social Service Workers	9,788	10,942	267,314	24.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	49,147	54,901	687,305	12.52	15
16	Dishwashers					16
17	Maintenance Workers	9,631	10,090	159,503	15.81	17
18	Housekeepers	44,002	47,819	589,573	12.33	18
19	Laundry	1,749	2,092	28,861	13.80	19
20	Administrator	1,770	2,086	138,604	66.44	20
21	Assistant Administrator	1,570	2,086	85,695	41.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,286	27,898	506,024	18.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,005	2,110	47,469	22.50	31
32	Other Health Ca <u>Schedule 20A</u>	16,901	19,358	753,769	38.94	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	464,916	507,086	\$ 9,856,923 *	\$ 19.44	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			35
36	Medical Director	monthly 63,000	9(5)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	monthly 21,743	10(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			45
46	Other(specify) <u>Dentist</u>	monthly 11,197	10(3)	46
47	<u>Infectious Disease Consultant</u>	monthly 1,950	10(3)	47
48	<u>Nephrology consultant</u>	monthly 4,800	10(3)	48
49	TOTAL (lines 35 - 48)	\$ 102,690		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	4 92	10(3)	52
53	TOTAL (lines 50 - 52)	4 \$ 92		53

Facility: Lieberman Geriatric Health Centre

Provider # 0026195

Period: 07/01/14 - 06/30/15

Schedule 20A

A. Staffing & Salary Costs

Line 32 - Other Healthcare

	Hours Worked	Hours Paid	Total Wages	Av Hourly Wage
Resident Care Manager	6,786	8,036	299,789	37.31
Resident Care Supervisor	5,746	6,270	261,575	41.72
Program Director, Alzheimer Special Care L	1,518	1,788	63,663	35.61
MDS Nurse	2,851	3,264	128,741	39.44
Totals to Page 20, Line 32	<u>16,901</u>	<u>19,358</u>	<u>753,768</u>	<u>38.94</u>

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Ronald Benner	Executive Director	0	\$ 138,604	Workers' Compensation Insurance	\$ 157,428	IDPH License Fee	\$ 1,275	
Anna-Liisa LaCroix	Dir of Operations and Ancillary Ser	0	85,695	Unemployment Compensation Insurance	79,687	Advertising: Employee Recruitment		
				FICA Taxes	749,728	Health Care Worker Background Check		
				Employee Health Insurance	1,526,571	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	430 4,228	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network of IL dues	20,453	
				Employee Long Term Disability	9,541			
				Employee Retirement	350,024			
				Employee Uniform Allowance	5,569			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 224,299	TOTAL (agree to Schedule V, line 22, col.8)		\$ 2,878,548	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other							Schedule 21A	
Description			Amount				33,719	
Fun Committee			\$ (294)				Less: Public Relations Expense ()	
Entertainment			7,331				Non-allowable advertising ()	
Marketing			31,817				Yellow page advertising ()	
Business Development			21,468					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 60,322				TOTAL (agree to Sch. V, line 24, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
RSM McGladrey	Audit Fees		\$ 13,586			\$	Out-of-State Travel	\$
Jewish Fed of Metro Chicago	Lobbying		18,504					
M DeBacker/V Edelstein	Medical Director		63,000					
Virginia Bradley	Clerical nursing services		46,689				In-State Travel	
Simply Rehab/Health Pro Rehab	Psychiatrist/Fitness		25,000					
Advanced Rehabilitation	Psychiatrist/Fitness		15,000					
Greenberg Traurig	Legal fees		35,235					
Polsinelli Shugart	Legal fees		42,940				Seminar Expense	5,572
Clauss Adr, Inc	Legal fees		338					
Richard M Stanton	Legal fees		500					
Village of Skokie	Legal fees		900					
See Schedule 21A			40,116				Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 301,806	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 5,572	

* Attach copy of IMRF notifications

**See instructions.

Facility: Lieberman Geriatric Health Centre
Provider # 26195
Period: 07/01/14 - 06/30/15

Schedule 21A

Schedule 21 C - Professional Services

Chicago Title Land Trust - annual fee	806.56	
Associated Agencies - surety bond (reclassified to line 26)	750.00	
Associated Agencies - malpractice (reclassified to line 26)	15,417.00	
EAC - elevator consultation	1,638.49	
FR&R - healthcare consultation	25.00	
Heartland Health Outreach - translator	66.25	
CARF International - customer service survey	1,525.00	
Zum Brennen, Inc - facility forecast study	6,287.73	
Focus on Aging - marketing analysis	8,800.00	
Nephrology consultant	4,800.00	recl to line 10
	<u>40,116.03</u>	

Schedule 21 F - Dues, Subscriptions, Licenses & Fees

Other

Ability Network - data support	5,511.00
Better Metal Systems - hood inspections	4,125.00
Chicago Backflow Inc - inspection	1,253.00
e-Health Data	7,220.46
CMS - Medicare Enrollment	542.00
Chicago Metropolitan fire - inspection	255.00
Dalmation Equipment - inspection	218.00
Esscoe - inspection	2,803.00
F.E. Moran - inspection	4,257.00
Fredriksen & Sons Fire Equipment - inspection	1,013.39
Illinois Emergency Management - annual registration	50.00
Illinois Office of the State Fire Marshal - boiler inspection	210.00
Village of Skokie - elevator inspection	220.00
Elevaotr Inspection Services	550.00
Management and Network Services	812.08
Med Pass - data support	36.00
Miscellaneous publications	1,159.75
National Notary Association	153.00
Nebo Systems - data support	240.00
Village of Skokie - fire alarm fee	20.00
Contract Plumbing - certification of kidney dialysis machine	875.00
Contract Plumbing -permit for kidney dialysis machine	150.00

Anderson Lock	728.04
Automated Scale	550.13
Village of Skokie bond refund	(1,000.00)
Comcast	1,765.74
	<u>33,718.59</u>

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

Facility Name & ID Number Lieberman Ctr for Hlth & Reh# 0026195Report Period Beginning: 07/01/2014Ending: 06/30/2015**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?
If YES, give association name and amount. Life Services Network - 20,453
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 125,322 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. _____
- (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. \$ 514,605
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. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 23,190
- (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? yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ not included in Lieberman income/expense
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: McGladrey
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. yes
Attach invoices and a summary of services for all architect and appraisal fees.

2015 Board of Directors	
Name	
Marilyn Altman	
Jordan C. Berger	
Marc L. Berman	
Charles M. Bley (Chuck)	
Michael D. Blum, M.D	
Sam Brilliant	
Gila J. Bronner	
*Arnold F. Brookstone	
*Dennis J. Carlin	
Steve Drucker	
Alan M. Ellenby	
James M. Feldman	
Terri Freeman	
Vern Gideon	
*Barbara A. Gilbert	
*William I. Goldberg	
Allan Goldstein	
Jeff Graff	
Mark Grazman	
*Alan I. Greene	
Harvey R. Kallick	
Mary Kaltman	
Dennis Kleper	
Michael E. Koen	
Richard M. Kohn	
*Bruce J. Lederman	
Kenneth F. Lorch	
Leslie Markman-Stern	
*James C. Mills	
Margo Fried Oberman	
Sheryl Oberman	
Vicki E. Pines	
John E. Pomeranz	
Susan A. Reese	
Carlton R. Resnick	
Steven Rogin	
David M. Rosenberg	
Karen Rosenthal	
*Mally Z. Rutkoff	

Stephen Sandler
*Robert L. Schlossberg
Susan Segal
Marci Shapiro
Judy L. Smith
Linda Soreff Siegel
Dianne Tesler
Randi S. Urkov
Kalman Wenig
Judith Wright Whellan
*Leonard A. Worssek

**Travel and Seminar XIX G
FY15**

Post date	Account	Journal	Journal reference	Transaction amount	Location of Event	Date of Event	Employee
8/31/14	20-100-5320	Accounts Payable	Life Services Network-RONALD BENNER-8/21/2014	\$180.00	Webinar	09/14	multiple
8/31/14	20-850-5320	Accounts Payable	Pathway Health Services I-3004 RONALD BEN-8/21/2014	\$95.00	Webinar	10/15	R Benner
9/15/14	20-850-5320	Accounts Payable	American Assoc. of Nurse -30960-9/4/2014	\$160.00	online recertification courses		
10/31/14	20-850-5320	Accounts Payable	Illinois Council On Long -RONALD BENNER-10/23/2014	\$660.00	Skokie, IL	11/12/2014	four employees
10/31/14	20-100-5320	Accounts Payable	Life Services Network-ANNA-LIISA LACR-9/30/2014	\$99.00	Webinar	2/25/2015	Jo Hammerman
11/11/14	20-840-5320	Accounts Payable	American Society On Aging-430454-11/3/2014	\$440.00	Chicago, IL	03/15	A Koch
11/11/14	20-840-5320	Accounts Payable	American Society On Aging-430454-11/3/2014	\$440.00	Chicago, IL	03/15	K Houpt
12/31/14	20-100-5320	Accounts Payable	Illinois Council On Long -RONALD BENNER-12/8/2014	\$660.00	Skokie, IL	11/12/2014	A LaCroix/R Benner/A Jalloh/L Soriano
2/28/15	20-100-5320	Accounts Payable	Life Services Network-RONALD BENNER-1/29/2015	\$99.00	Webinar	2/25/2015	R Benner
2/28/15	20-100-5320	Accounts Payable	Illinois Council On Long -RONALD BENNER-2/19/2015	\$330.00	Skokie, IL	03/10/03/12/2015	S Gordon/A LaCroix
2/28/15	20-840-5320	Accounts Payable	Comprehensive Group-HealthPro-Rehab-1/30/2015	\$158.00	cannot find invoice		
3/31/15	20-840-5320	Accounts Payable	Northern Illinois Univers-3362678444 CJE -3/20/2015	\$182.40	Rosemont, IL	04/29-05/01/15	A Jalloh
3/31/15	20-840-5320	Accounts Payable	Northern Illinois Univers-3362678444 CJE -3/20/2015	\$182.40	Rosemont, IL	04/29-05/01/15	A LaCroix
3/31/15	20-100-5320	Accounts Payable	Northern Illinois Univers-3362678444 CJE -3/20/2015	\$182.40	Rosemont, IL	04/29-05/01/15	R Benner
3/31/15	20-100-5320	Accounts Payable	Northern Illinois Univers-3362678444 CJE -3/20/2015	\$182.40	Rosemont, IL	04/29-05/01/15	L Soriano
3/31/15	20-100-5320	Accounts Payable	Northern Illinois Univers-3362678444 CJE -3/20/2015	\$182.40	Rosemont, IL	04/29-05/01/15	W Turner
3/31/15	20-100-5320	Accounts Payable	Northern Illinois Univers-3362678444 CJE -3/20/2015	\$182.40	Rosemont, IL	04/29-05/01/15	V Wells
3/31/15	20-850-5320	Accounts Payable	Jewish Child and Family S-4 RONALD BENNER-3/16/2015	\$15.00	Chicago, IL	3/12/2015	E Pruzenski
3/31/15	20-850-5320	Accounts Payable	Northern Illinois Univers-3362678444 CJE -3/20/2015	\$182.40	Rosemont, IL	04/29-05/01/15	L Tomakova
3/31/15	20-850-5320	Accounts Payable	Northern Illinois Univers-3362678444 CJE -3/20/2015	\$182.40	Rosemont, IL	04/29-05/01/15	K Houpt
3/31/15	20-850-5320	Accounts Payable	Northern Illinois Univers-3362678444 CJE -3/20/2015	\$182.40	Rosemont, IL	04/29-05/01/15	D Coleman
5/31/15	20-850-5320	Accounts Payable	FR&R Healthcare Consultin-RONALD BENNER-4/30/2015	\$595.00	ICD-10 webinar	05/07-06/16/15	multiple
6/28/15	20-100-5320	General Ledger	S 06 089 Record NIU Outreach Chase Credit Card Credit	(\$0.69)			credit

\$5,571.91

Position

Executive Director

Mgr, Mental Health

Mgr, Life Enrichment

Art Therapist

Dir of Oper/Exec Dir/ADON/MDS nurse

Executive Director

Dir of Health Serv/Dir of Operations

ADON

Dir of Oper

Executive Director

MDS nurse

Activity Coordinator

Mgr, HR

Transitional Care Nurse

Dir, Environmental Services

Art Therapist

Marketing and Outreach Mgr