FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 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 1/1/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) 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: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	26,352	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	26,352	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	20,146	269	1,960	22,375	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,146	269	1,960	22,375	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.91%

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 9/1/09

J. Was the facility purchased or leased after January 1, 1978?
YES [X] 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 1,747

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	177,123	16,826	5,227	199,176		199,176		199,176			1
2	Food Purchase		128,702		128,702		128,702	(8)	128,694			2
3	Housekeeping	103,379	12,471		115,850		115,850		115,850			3
4	Laundry	32,562	3,829		36,391		36,391		36,391			4
5	Heat and Other Utilities			101,888	101,888		101,888	1,092	102,980			5
6	Maintenance	32,663	10,038	24,262	66,963		66,963	32,840	99,803			6
7	Other (specify):*											7
8	TOTAL General Services	345,727	171,866	131,377	648,970		648,970	33,924	682,894			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,126,288	59,786	1,720	1,187,794		1,187,794		1,187,794			10
10a	Therapy			312,585	312,585		312,585		312,585			10a
11	Activities	61,887	4,959		66,846		66,846		66,846			11
12	Social Services	34,413		2,569	36,982		36,982		36,982			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			6,745	6,745		6,745		6,745			15
16	TOTAL Health Care and Programs	1,222,588	64,745	332,019	1,619,352		1,619,352		1,619,352			16
	C. General Administration											
17	Administrative	89,389			89,389		89,389		89,389			17
18	Directors Fees											18
19	Professional Services			420,492	420,492		420,492	(337,175)	83,317			19
20	Dues, Fees, Subscriptions & Promotions			4,283	4,283		4,283	547	4,830			20
21	Clerical & General Office Expenses	126,612	17,321	30,933	174,866		174,866	61,713	236,579			21
22	Employee Benefits & Payroll Taxes			475,105	475,105		475,105	6,178	481,283			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,731	8,731		8,731	28,437	37,168			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			192,000	192,000		192,000	153,104	345,104			26
27	Other (specify):*											27
28	TOTAL General Administration	216,001	17,321	1,131,544	1,364,866		1,364,866	(87,196)	1,277,670			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,784,316	253,932	1,594,940	3,633,188		3,633,188	(53,272)	3,579,916			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: 1/1/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			24,534	24,534		24,534	99,924	124,458			30
31	Amortization of Pre-Op. & Org.							60,145	60,145			31
32	Interest			187	187		187	128,630	128,817			32
33	Real Estate Taxes			245,345	245,345		245,345	215,576	460,921			33
34	Rent-Facility & Grounds			367,522	367,522		367,522	(362,794)	4,728			34
35	Rent-Equipment & Vehicles							437	437			35
36	Other (specify):*											36
37	**TOTAL Ownership**			637,588	637,588		637,588	141,918	779,506			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			666	666		666		666			38
39	Ancillary Service Centers		58,539		58,539		58,539		58,539			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,382	164,382		164,382		164,382			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		58,539	165,048	223,587		223,587		223,587			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,784,316	312,471	2,397,576	4,494,363		4,494,363	88,646	4,583,009			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: 1/1/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	72,587	30		9
10	Interest and Other Investment Income	(499)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,256)	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	(1,200)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 65,624		$	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)	23,022	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 23,022		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 88,646		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Berkeley Nrsg & Rehab Center

ID# 0050534

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,200)	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**	(1,200)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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	(8)	0	0	0	0	0	0	0	0	0	0	(8)	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	1,092	0	0	0	0	0	0	0	0	0	1,092	5
6	Maintenance	0	200	32,640	0	0	0	0	0	0	0	0	32,840	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8)	1,292	32,640	0	0	0	0	0	0	0	0	33,924	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	(89,900)	(247,275)	0	0	0	0	0	0	0	0	(337,175)	19
20	Fees, Subscriptions & Promotions	0	22	525	0	0	0	0	0	0	0	0	547	20
21	Clerical & General Office Expenses	(6,456)	66,613	1,556	0	0	0	0	0	0	0	0	61,713	21
22	Employee Benefits & Payroll Taxes	0	6,178	0	0	0	0	0	0	0	0	0	6,178	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,935	26,502	0	0	0	0	0	0	0	0	28,437	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	117	152,987	0	0	0	0	0	0	0	0	153,104	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,456)	(15,035)	(65,705)	0	0	0	0	0	0	0	0	(87,196)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,464)	(13,743)	(33,065)	0	0	0	0	0	0	0	0	(53,272)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	72,587	415	26,922	0	0	0	0	0	0	0	0	99,924	30
31	Amortization of Pre-Op. & Org.	0	0	60,145	0	0	0	0	0	0	0	0	60,145	31
32	Interest	(499)	0	129,129	0	0	0	0	0	0	0	0	128,630	32
33	Real Estate Taxes	0	0	215,576	0	0	0	0	0	0	0	0	215,576	33
34	Rent-Facility & Grounds	0	3,728	(366,522)	0	0	0	0	0	0	0	0	(362,794)	34
35	Rent-Equipment & Vehicles	0	437	0	0	0	0	0	0	0	0	0	437	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	72,088	4,580	65,250	0	0	0	0	0	0	0	0	141,918	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)**	65,624	(9,163)	32,185	0	0	0	0	0	0	0	0	88,646	45

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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		$ 1,092	$ 1,092	1
2	V	6	Repairs		Senior Healthcare Management		200	200	2
3	V	19	Professional Services	91,000	Senior Healthcare Management		1,100	(89,900)	3
4	V	20	Licenses & Fees		Senior Healthcare Management		22	22	4
5	V	21	Office Supplies		Senior Healthcare Management		1,496	1,496	5
6	V	21	Office Expense		Senior Healthcare Management		382	382	6
7	V	21	Payroll		Senior Healthcare Management		64,735	64,735	7
8	V	22	Employee Benefits		Senior Healthcare Management		6,178	6,178	8
9	V	24	Travel/Seminar		Senior Healthcare Management		1,935	1,935	9
10	V	26	Insurance		Senior Healthcare Management		117	117	10
11	V	30	Depreciation Expense		Senior Healthcare Management		415	415	11
12	V	34	Rent Expense		Senior Healthcare Management		3,728	3,728	12
13	V	35	Equipment Lease		Senior Healthcare Management		437	437	13
14	Total			$ 91,000			$ 81,837	$ * (9,163)	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: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$ 252,000	JB Healthcare		$ 3,975	$ (248,025)	15
16	V	20	Dues & Subscriptions		JB Healthcare		250	250	16
17	V	21	Office Supplies		JB Healthcare		199	199	17
18	V	21	Office Expenses		JB Healthcare		1,357	1,357	18
19	V	24	Travel		JB Healthcare		26,502	26,502	19
20	V	32	Interest		JB Healthcare		42	42	20
21	V	34	Rent		JB Healthcare		1,000	1,000	21
22	V								22
23	V	6	Repairs & Maintenance		Woodbine Nursing Realty		32,640	32,640	23
24	V	19	Professional Fees		Woodbine Nursing Realty		750	750	24
25	V	20	Dues & Subscriptions		Woodbine Nursing Realty		275	275	25
26	V	26	Insurance		Woodbine Nursing Realty		152,987	152,987	26
27	V	30	Depreciation		Woodbine Nursing Realty		26,922	26,922	27
28	V	31	Amortization		Woodbine Nursing Realty		60,145	60,145	28
29	V	32	Interest		Woodbine Nursing Realty		129,087	129,087	29
30	V	33	Property Tax		Woodbine Nursing Realty		215,576	215,576	30
31	V	34	Rent	367,522	Woodbine Nursing Realty			(367,522)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 619,522			$ 651,707	$ * 32,185	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: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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: 1/1/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] 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: 1/1/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	HUD Mortgage		X	Mortgage	$37,689.00	8/24/12	$ 3,614,600	$ 3,233,858	9/1/40	2.8500	$ 128,630	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank & Trust		X	Workign Capital	None	8/31/11	175,000	175,000	8/31/17	5.5000	187	6
7												7
8												8
9	TOTAL Facility Related				$37,689.00		$ 3,789,600	$ 3,408,858			$ 128,817	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,789,600	$ 3,408,858			$ 128,817	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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.)**

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	395,294	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.)	$	186,995	2
3. Under or (over) accrual (line 2 minus line 1).	$	(208,299)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	453,644	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.	$	245,345	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	138,440	8
	2012	143,700	9
	2013	143,746	10
	2014	173,763	11
	2015	186,995	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-06-104-029-000	6909 North Ave, Chicago, IL	$ 186,994.70	$ 186,994.70
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 186,994.70	$ 186,994.70

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

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		2009		$ 1,050,000	$ 26,922	39	$ 26,923	$ 1	$ 114,422	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		9,934	9
10	Cabinets/Carpet Removal & Plumbing Work			10/16/2009	1,872	48	39	48		335	10
11	New Acrylic Signs			9/21/2009	1,500	38	39	38		268	11
12	Cabling for Beds & Dining Room			3/15/2010	2,000	51	39	51		350	12
13	Bathroom Remodeling, Plumbing, and Materials			3/18/2010	2,588	66	39	66		453	13
14	Sprinkler System Repairs			8/27/2010	2,821	72	39	72		464	14
15	Sprinkler System Repairs			10/7/2010	4,579	117	39	117		734	15
16	Sprinkler System Repairs			10/21/2010	1,159	30	39	30		186	16
17	Sink and Drain Repairs			1/7/2010	6,475	166	39	166		1,044	17
18	Replacement Chiller Coil for Air Handler Unit			6/22/2010	4,125	106	39	106		696	18
19	Chiller Coil Installation			6/23/2010	1,583	41	39	41		267	19
20	Replacement Dryer Exhaust			7/13/2010	1,000	26	39	26		167	20
21	Replacement Fire Damper Motor			8/19/2010	1,556	40	39	40		256	21
22	Heating Systems Repair			11/1/2010	2,617	67	39	67		414	22
23	Awning			4/20/2010	2,500	64	39	64		433	23
24	Sprinkler System Repairs			7/16/2011	1,800	46	39	46		254	24
25	Plumbing Work			4/21/2011	3,250	83	39	83		449	25
26	New Flooring			7/19/2011	1,440	37	39	37		203	26
27	New Locks & Handles for Doors			4/4/2012	3,800	97	39	97		463	27
28	New Handrails & Repave Parking Lot			4/4/2012	11,455	294	39	294		1,395	28
29	Plumbing Work & Replace Floor Tiles			6/22/2012	15,000	385	39	385		1,763	29
30	Install Railings & Posts			6/22/2012	5,000	128	39	128		587	30
31	Outdoor cameras			10/22/2012	19,028	781	39	488	(293)	17,856	31
32	Relocate nurses call system			12/9/2012	3,414	140	39	88	(52)	3,204	32
33	Remodel dining room, nurses station, lobby & office			8/9/2012	309,000	7,923	39	7,923		34,412	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: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	* Install window, handrails, stone on walls in kitchen opening,	9/25/2013	$ 116,825	$ 2,996	39	$ 2,996	$	$ 9,861	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		11,795	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		325	53
54									54
55	Flooring in resident rooms, cove base, wall coverings, painting,	5/15/2015	44,407	1,139	39	1,139		1,661	55
56	electrical, new closet dividers, ceiling tiles, plumbing in bathrooms								56
57	Tile and grout in bathrooms								57
58									58
59	Replace 10' of cast iron plumbing pipe	2016	1,950	23	39	1,950	1,927	23	59
60	Wall coverings, light fix, tile, electrical work in resident rooms	2016	24,697	290	39	24,697	24,407	290	60
61	New pit ladder installation	2016	2,801	33	39	2,801	2,768	33	61
62	Replace mixing valve	2016	3,272	38	39	3,272	3,234	38	62
63	Laundry fan replacement	2016	2,350	28	39	2,350	2,322	28	63
64	New water heater	2016	4,413	52	39	4,413	4,361	52	64
65	New roof fan	2016	5,200	61	39	5,200	5,139	61	65
66	New A/C blower motor	2016	1,292	15	39	1,292	1,277	15	66
67	New fan vent	2016	950	11	39	950	939	11	67
68	New fire panel board	2016	2,475	29	39	2,475	2,446	29	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,882,994	$ 47,939		$ 96,415	$ 48,476	$ 215,231	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: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,882,994	$ 47,939		$ 96,415	$ 48,476	$ 215,231	1
2	Replace existing outdoor carpet, debris container and	2016	108,800	1,279	39	1,279		1,279	2
3	removal, removal of existing floor and wall tiles in 11								3
4	resident rooms								4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,991,794	$ 49,218		$ 97,694	$ 48,476	$ 216,510	34

**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: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 101,957	$ 1,891	$ 20,391	$ 18,500	5	$ 98,464	71
72	Current Year Purchases	31,864	347	6,373	6,026	5	3,187	72
73	Fully Depreciated Assets	975,000				5	975,000	73
74								74
75	TOTALS	$ 1,108,821	$ 2,238	$ 26,764	$ 24,526		$ 1,076,651	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)	$ 3,350,615	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,456	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 124,458	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 73,002	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,293,161	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: 1/1/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 1/1/2016 Ending: 12/31/2016

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	2,170	$ 119,362	$	2,170	$ 119,362	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,275	72,096		1,275	72,096	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,878	121,127		1,878	121,127	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				56,077		56,077	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Xray & Lab	39-2					2,462		2,462	12
13	Other (specify):									13
14	TOTAL			$	5,323	$ 312,585	$ 58,539	5,323	$ 371,124	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 Berkeley Nrsg & Rehab Center **#** 0050534 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 38,729	$ 191,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,257,872	1,257,872	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	284,664	284,664	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Replacement Reserve	(367,450)	(270,017)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,213,815	$ 1,463,519	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	925,600	925,600	15
16	Equipment, at Historical Cost	149,946	1,124,946	16
17	Accumulated Depreciation (book methods)	(203,709)	(1,357,293)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,000,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(550,597)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Escrows & Refinance		132,081	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 871,837	$ 2,574,737	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,085,652	$ 4,038,256	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 664,686	$ 885,679	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	177,377	177,377	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)**	$ 842,063	$ 1,063,056	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	175,000	175,000	39
40	Mortgage Payable		3,233,858	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)**	$ 175,000	$ 3,408,858	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,017,063	$ 4,471,914	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,068,589	$ (433,658)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,085,652	$ 4,038,256	48

***(See instructions.)**

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,350,567	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,350,567	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(281,971)	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) **Rounding**	(7)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (281,978)	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)**	$ 1,068,589	24 *

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

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,105,353	1
2	Discounts and Allowances for all Levels	(592,704)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,512,649	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	647,703	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 647,703	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	39,044	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,297	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 50,341	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	499	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 499	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	1,200	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,200	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,212,392	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	648,969	31
32	Health Care	1,619,353	32
33	General Administration	1,364,866	33
	B. Capital Expense		
34	Ownership	637,588	34
	C. Ancillary Expense		
35	Special Cost Centers	59,205	35
36	Provider Participation Fee	164,382	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,494,363	40
41	**Income before Income Taxes (line 30 minus line 40)****	(281,971)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (281,971)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,901,516	44
45	Private Pay - Net Inpatient Revenue	18,216	45
46	Medicare - Net Inpatient Revenue	941,449	46
47	Other-(specify)	(348,531)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,512,650	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: 1/1/2016 Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,053	2,240	$ 87,723	$ 39.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,901	8,233	254,372	30.90	3
4	Licensed Practical Nurses	11,416	12,078	317,025	26.25	4
5	CNAs & Orderlies	37,101	38,948	400,595	10.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,022	5,366	61,887	11.53	10
11	Social Service Workers	1,906	2,153	34,413	15.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,133	15,934	177,123	11.12	15
16	Dishwashers					16
17	Maintenance Workers	2,014	2,077	32,663	15.73	17
18	Housekeepers	10,589	11,253	103,379	9.19	18
19	Laundry	2,991	3,288	32,562	9.90	19
20	Administrator	2,023	2,230	89,389	40.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,280	6,889	76,334	11.08	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	1,976	2,182	23,181	10.62	31
32	Other Health C: Admission Cord	2,035	2,091	50,278	24.04	32
33	Other(specify) MDS	1,139	1,229	43,392	35.31	33
34	TOTAL (lines 1 - 33)	109,579	116,191	$ 1,784,316 *	$ 15.36	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	149	$ 5,227	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	49	1,720	10-3	38
39	Pharmacist Consultant	135	6,745	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	73	2,569	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	406	$ 16,261		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: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Daugherty	Administrator		$ 28,196
Theodora Schild	Administrator		61,193
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,389

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
Sandberg Phoenix	Legal	$ 7,359
Neal, Gerber, & Eisenberg	Legal	8,082
Gory Law Firm	Legal	40,000
Various	Legal	4,292
Bradley Associates	Accounting	7,510
Barnes, Dennig, & Co.	Accounting	4,700
Johnson, Goldber, & Brown	Accounting	3,000
Senior Healthcare Management	Prof/Mgmt Fees	91,000
MTS Consulting	Professional Fees	2,549
JB Healthcare	Prof/Mgmt Fees	252,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 420,492

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,214
Unemployment Compensation Insurance	78,828
FICA Taxes	139,819
Employee Health Insurance	142,158
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	17,549
Employee Expense	18,715
TOTAL (agree to Schedule V, line 22, col.8)	$ 481,283

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Village of Oak Park	1,350
Certificate of Operation	168
Illinois Fire Marshall	300
Various	1,022
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,830

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	1,360
Mgmt Co. Gas & Lodging	28,437
Mileage	5,212
Seminar Expense	
Education	2,159
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 37,168

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 politica
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. $ **19,027** 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 fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **164,382**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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