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.

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

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: 708-426-2315 **Fax #** 708-426-2415

HFS ID Number:

Date of Initial License for Current Owners: 09/01/09

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: Aaron Mauer **Telephone Number:** 773-747-4506
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 1/1/20 to 12/31/20 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) 5/28/2021 (Date)
(Type or Print Name) Alan Irni
(Title) CFO

Paid Preparer

(Signed) 5/28/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

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: 1/1/20 Ending: 12/31/20

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 NA

	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	16,776	826	1,707	19,309	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,776	826	1,707	19,309	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.27%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 09/01/09

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/09 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 1,342

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	249,306	16,218	7,164	272,688		272,688	(21)	272,667			1
2	Food Purchase		115,233		115,233		115,233		115,233			2
3	Housekeeping	163,064	17,667		180,731		180,731		180,731			3
4	Laundry	75,272	7,849		83,121		83,121		83,121			4
5	Heat and Other Utilities			93,425	93,425		93,425		93,425			5
6	Maintenance	40,209	8,436	45,584	94,229		94,229		94,229			6
7	Other (specify):*											7
8	**TOTAL General Services**	527,851	165,403	146,173	839,427		839,427	(21)	839,406			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,388,588	52,490	90,190	1,531,268		1,531,268		1,531,268			10
10a	Therapy			306,672	306,672		306,672		306,672			10a
11	Activities	142,771	6,122		148,893		148,893	(422)	148,471			11
12	Social Services	30,440		1,764	32,204		32,204		32,204			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			5,742	5,742		5,742		5,742			15
16	**TOTAL Health Care and Programs**	1,561,799	58,612	412,768	2,033,179		2,033,179	(422)	2,032,757			16
	C. General Administration											
17	Administrative	75,780			75,780		75,780		75,780			17
18	Directors Fees											18
19	Professional Services			433,946	433,946		433,946	(294,850)	139,096			19
20	Dues, Fees, Subscriptions & Promotions			3,769	3,769		3,769	125	3,894			20
21	Clerical & General Office Expenses	84,211	17,629	36,768	138,608		138,608	(1,625)	136,983			21
22	Employee Benefits & Payroll Taxes			490,222	490,222		490,222		490,222			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,292	19,292		19,292		19,292			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			274,935	274,935		274,935	531,007	805,942			26
27	Other (specify):*											27
28	**TOTAL General Administration**	159,991	17,629	1,258,932	1,436,552		1,436,552	234,657	1,671,209			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,249,641	241,644	1,817,873	4,309,158		4,309,158	234,214	4,543,372			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: 1/1/20 Ending: 12/31/20

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			64,173	64,173		64,173	8,301	72,474			30
31	Amortization of Pre-Op. & Org.							67,812	67,812			31
32	Interest			16,597	16,597		16,597	76,067	92,664			32
33	Real Estate Taxes			253,572	253,572		253,572	(852,416)	(598,844)			33
34	Rent-Facility & Grounds			324,237	324,237		324,237	209,271	533,508			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			658,579	658,579		658,579	(490,965)	167,614			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			98	98		98		98			38
39	Ancillary Service Centers		61,676		61,676		61,676		61,676			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,965	151,965		151,965		151,965			42
43	Other (specify):* **Bad Debt Expense**			190,665	190,665		190,665	(190,665)				43
44	**TOTAL Special Cost Centers**		61,676	342,728	404,404		404,404	(190,665)	213,739			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,249,641	303,320	2,819,180	5,372,141		5,372,141	(447,416)	4,924,725			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: 1/1/20 Ending: 12/31/20

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 Reference	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	(18,621)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	1		13
14	Non-Care Related Interest	(7,563)	32		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	(1,625)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(190,665)	43		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	(422)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (218,917)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (228,499)	Various	36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (447,416)		37

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

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

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

Berkeley Nrsg Rehab Center

ID# 0050534

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income - Activity	$ (422)	11	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**	(422)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(21)	0	0	0	0	0	0	0	0	0	0	(21)	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**	(21)	0	0	0	0	0	0	0	0	0	0	(21)	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	(422)	0	0	0	0	0	0	0	0	0	0	(422)	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**	(422)	0	0	0	0	0	0	0	0	0	0	(422)	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	(294,850)	0	0	0	0	0	0	0	0	0	(294,850)	19
20	Fees, Subscriptions & Promotions	0	125	0	0	0	0	0	0	0	0	0	125	20
21	Clerical & General Office Expenses	(1,625)	0	0	0	0	0	0	0	0	0	0	(1,625)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	531,007	0	0	0	0	0	0	0	0	0	531,007	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,625)	236,282	0	0	0	0	0	0	0	0	0	234,657	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,068)	236,282	0	0	0	0	0	0	0	0	0	234,214	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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	(18,621)	26,922	0	0	0	0	0	0	0	0	0	8,301	30
31	Amortization of Pre-Op. & Org.	0	67,812	0	0	0	0	0	0	0	0	0	67,812	31
32	Interest	(7,563)	83,630	0	0	0	0	0	0	0	0	0	76,067	32
33	Real Estate Taxes	0	(852,416)	0	0	0	0	0	0	0	0	0	(852,416)	33
34	Rent-Facility & Grounds	0	209,271	0	0	0	0	0	0	0	0	0	209,271	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**	(26,184)	(464,781)	0	0	0	0	0	0	0	0	0	(490,965)	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):*	(190,665)	0	0	0	0	0	0	0	0	0	0	(190,665)	43
44	**TOTAL Special Cost Centers**	(190,665)	0	0	0	0	0	0	0	0	0	0	(190,665)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(218,917)	(228,499)	0	0	0	0	0	0	0	0	0	(447,416)	45

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Management Co.
Nancy Blisko	1			Woodbine Realty	Oak Park	Realty 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	33	Rent	$ 852,416	Woodbine Realty		$	$ (852,416)	1
2	V	34	Real Estate Taxes		Woodbine Realty		209,271	209,271	2
3	V	26	Insurance-Prop.Liab		Woodbine Realty		531,007	531,007	3
4	V	32	Interest		Woodbine Realty		83,630	83,630	4
5	V	19	Professional Fees		Woodbine Realty		5,150	5,150	5
6	V	20	Dues and Subs		Woodbine Realty		125	125	6
7	V	30	Depreciation		Woodbine Realty		26,922	26,922	7
8	V	31	Amortization		Woodbine Realty		67,812	67,812	8
9	V	19	Professional Fees	300,000	JB Healthcare			(300,000)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,152,416			$ 923,917	$ * (228,499)	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: 1/1/20 Ending: 12/31/20

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: 1/1/20 Ending: 12/31/20

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									$		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: 1/1/20 Ending: 12/31/20

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: 1/1/20 Ending: 12/31/20

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		X	Mortgage	Various	8/24/12	$ 3,614,600	$ 2,730,630	9/1/40	2.8500	$ 83,630	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Highland Park Bank		X	Working Capital	None	8/31/18	800,000			5.7500	16,597	6
7												7
8												8
9	TOTAL Facility Related						$ 4,414,600	$ 2,730,630			$ 100,227	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,414,600	$ 2,730,630			$ 100,227	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 14,522 Line # 26

* 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: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 498,006	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.)		$ 209,668	2
3. Under or (over) accrual (line 2 minus line 1).		$ (288,338)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.)		$ 541,910	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.		$ 253,572	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	186,995	8
	2016	189,376	9
	2017	197,385	10
	2018	201,808	11
	2019	209,668	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Berkeley Nrsg Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050534

CONTACT PERSON REGARDING THIS REPORT Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-06-104-029-0000	Nursing Facility	$ 209,667.58	$ 209,667.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 209,667.58	$ 209,667.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/20 Ending: 12/31/20

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).

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: 1/1/20 Ending: 12/31/20

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			2009		$ 1,050,000	$ 26,922	39	$ 26,922	$	$ 245,000	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		15,370	9
10	Cabinets/Carpet Removal & Plumbing Work			10/16/2009	1,872	48	39	48		527	10
11	New Acrylic Signs			9/21/2009	1,500	38	39	38		421	11
12	Cabling for Beds & Dining Room			3/15/2010	2,000	51	39	51		556	12
13	Bathroom Remodeling, Plumbing, and Materials			3/18/2010	2,588	66	39	66		719	13
14	Sprinkler System Repairs			8/27/2010	2,821	72	39	72		754	14
15	Sprinkler System Repairs			10/7/2010	4,579	117	39	117		1,204	15
16	Sprinkler System Repairs			10/21/2010	1,159	30	39	30		304	16
17	Sink and Drain Repairs			1/7/2010	6,475	166	39	166		1,707	17
18	Replacement Chiller Coil for Air Handler Unit			6/22/2010	4,125	106	39	106		1,120	18
19	Chiller Coil Installation			6/23/2010	1,583	41	39	41		429	19
20	Replacement Dryer Exhaust			7/13/2010	1,000	26	39	26		269	20
21	Replacement Fire Damper Motor			8/19/2010	1,556	40	39	40		416	21
22	Heating Systems Repair			11/1/2010	2,617	67	39	67		682	22
23	Awning			4/20/2010	2,500	64	39	64		689	23
24	Sprinkler System Repairs			7/16/2011	1,800	46	39	46		437	24
25	Plumbing Work			4/21/2011	3,250	83	39	83		783	25
26	New Flooring			7/19/2011	1,440	37	39	37		351	26
27	High resolution outdoor cameras			10/22/2012	19,028		39	488	488	2,709	27
28	Relocate nurses call system			12/9/2012	3,414		39	88	88	498	28
29	Provide door hardware			4/4/2012	3,800	97	39	97		750	29
30	Remove and repair Handrails			4/4/2012	11,455	294	39	294		2,259	30
31	Renovation of bathroom			6/22/2012	20,000	513	39	513		3,946	31
32	Integra Development			8/9/2012	309,000	7,923	39	7,923		60,954	32
33											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: 1/1/20 Ending: 12/31/20

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,	9/23/2013	$ 116,825	$ 2,996	39	$ 2,996	$	$ 21,844	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		27,743	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		766	53
54									54
55	Flooring in resident rooms, cove base, wall coverings, painting,								55
56	electrical, new closet dividers, ceiling tiles, plumbing in bathrooms								56
57	Tile and grout in bathrooms	5/15/2015	44,407	1,139	39	1,139		6,216	57
58									58
59	Replace 10' of cast iron plumbing pipe	2016	1,950	50	39	50		223	59
60	Wall coverings, light fix, tile, electrical work in resident rooms	2016	24,697	633	39	633		2,824	60
61	New pit ladder installation	2016	2,801	72	39	72		321	61
62	Replace mixing valve	2016	3,272	84	39	84		374	62
63	Laundry fan replacement	2016	2,350	60	39	60		269	63
64	New water heater	2016	4,413	113	39	113		504	64
65	New roof fan	2016	5,200	133	39	133		595	65
66	New A/C blower motor	2016	1,292	33	39	33		147	66
67	New fan vent	2016	950	24	39	24		109	67
68	New fire panel board	2016	2,475	63	39	63		283	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,882,994	$ 47,706		$ 48,281	$ 575	$ 405,070	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: 1/1/20 Ending: 12/31/20

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	$ 47,706		$ 48,281	$ 575	$ 405,070	1
2	Replace existing outdoor carpet, debris container and	2016	108,800	2,790	39	2,790		12,436	2
3	removal, removal of existing floor and wall tiles in 11								3
4	resident rooms								4
5									5
6	New floor and wall tile and plumbing work in shower room	2017	17,986	461	39	461		1,614	6
7	New compressor	2017	10,500	269	39	269		942	7
8	New sidewalk	2017	8,100	208	39	208		727	8
9	Cooling tower and building circulation pump	2017	6,300	162	39	162		566	9
10					39				10
11	New Elevator Door	2017	3,800	97	39	97		341	11
12	Electrical work in patient care areas	2017	28,450	729	39	729		2,552	12
13									13
14	Install new security cameras	2018	1,328	34	39	34		85	14
15	Install new exhaust fan in heating unit	2018	2,788	71	39	71		179	15
16	Replace electrical box	2018	1,150	29	39	29		74	16
17									17
18	Walls	2019	2,700	69	39	69		104	18
19	Cooling Tower	2019	16,500	423	39	423		635	19
20	Valve Replacement	2019	6,100	156	39	156		235	20
21	Fire Sprinkler System Repair	2019	7,905	203	39	203		304	21
22	New Heater Installed	2019	3,850	99	39	99		148	22
23	Elevator Contract Work	2019	2,896	74	39	74		111	23
24	Installation of Metal Door	2019	2,800	72	39	72		108	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)		$ 2,114,947	$ 53,653		$ 54,229	$ 575	$ 426,232	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: 1/1/20 Ending: 12/31/20

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	$ 77,666	$ 10,309	$ 15,533	$ 5,224	5	$ 63,830	71
72	Current Year Purchases	27,134	27,134	2,713	(24,421)	5	27,134	72
73	Fully Depreciated Assets	1,094,072				5	1,094,072	73
74								74
75	TOTALS	$ 1,198,872	$ 37,443	$ 18,247	$ (19,196)		$ 1,185,036	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)	$ 3,563,819	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 91,096	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,475	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (18,621)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,611,268	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: 1/1/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: 1/1/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	1,969	$ 145,480	$	1,969	$ 145,480	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		283	35,234		283	35,234	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,236	125,958		2,236	125,958	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				61,676		61,676	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					5,500		5,500	12
13	Other (specify): Lab	39-2					206		206	13
14	TOTAL			$	4,488	$ 306,672	$ 67,382	4,488	$ 374,054	14

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

STATE OF ILLINOIS

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 184,145	$ 185,380	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,337,306	1,768,887	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	192,397	192,397	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	179,490	535,659	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,893,338	$ 2,682,323	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		2,025,000	14
15	Leasehold Improvements, at Historical Cost	1,050,045	1,050,045	15
16	Equipment, at Historical Cost	218,706	218,706	16
17	Accumulated Depreciation (book methods)	(394,078)	(1,671,282)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,040,073	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(805,913)	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)**	$ 874,673	$ 2,106,629	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,768,011	$ 4,788,952	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,272,120	$ 1,371,152	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	475,478	726,049	29
30	Accrued Salaries Payable	156,065	156,065	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)**	$ 1,903,663	$ 2,253,266	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,730,630	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)**	$	$ 2,730,630	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,903,663	$ 4,983,896	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 864,348	$ (194,944)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,768,011	$ 4,788,952	48

*(See instructions.)

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 438,021	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 438,021	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	426,325	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)**	$ 426,325	17
	B. Transfers (Itemize):		
18	Rounding	2	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 864,348	24 *

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 5,099,876	1
2	Discounts and Allowances for all Levels	(84,632)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,015,244	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	255,134	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 255,134	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	515,087	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	375	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 515,462	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,563	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,563	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	1,200	28
28a	Mis Income	3,863	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,063	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,798,466	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	839,427	31
32	Health Care	2,033,179	32
33	General Administration	1,436,552	33
	B. Capital Expense		
34	Ownership	658,579	34
	C. Ancillary Expense		
35	Special Cost Centers	404,404	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,372,141	40
41	**Income before Income Taxes (line 30 minus line 40)****	426,325	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 426,325	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,912,494	44
45	Private Pay - Net Inpatient Revenue	109,995	45
46	Medicare - Net Inpatient Revenue	691,147	46
47	Other-(specify) Insurance	284,703	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,998,339	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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: 1/1/20 Ending: 12/31/20

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	2,080	2,080	$ 72,730	$ 34.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,179	2,195	185,995	84.74	3
4	Licensed Practical Nurses	3,242	3,405	333,913	98.07	4
5	CNAs & Orderlies	27,809	28,987	600,925	20.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,664	8,059	142,771	17.72	10
11	Social Service Workers	2,080	2,080	30,440	14.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,845	8,240	249,306	30.26	15
16	Dishwashers					16
17	Maintenance Workers	1,866	2,021	40,209	19.90	17
18	Housekeepers	9,246	9,600	163,064	16.99	18
19	Laundry	4,394	4,820	75,272	15.62	19
20	Administrator	2,080	2,080	75,780	36.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,275	3,450	84,211	24.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,909	4,019	81,923	20.38	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	1,847	1,917	113,103	59.00	33
34	TOTAL (lines 1 - 33)	79,516	82,953	$ 2,249,642 *	$ 27.12	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	Monthly	$ 7,164	1-3	35
36	Medical Director	Monthly	8,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	90,190	10-3	38
39	Pharmacist Consultant	Monthly	5,742	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	Monthly	1,764	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 113,260		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: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
OGUNNIYI, RICHARD A.	Administrator	0	$ 62,793
PATTON, TARCIA	Administrator	0	12,986
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,779

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
Integrity HCC Services	Accounting Fees	$ 103,842
GGM Associates Inc	Accounting Fees	6,000
JB Healthcare	Management Fees	300,000
SKIDELSKY & ASSOCIATES	Legal Fees	(23)
Real Estate Analysis Corporation - Jo	Professional fees	4,000
MTS CONSULTING LLC	Professional fees	8,166
Stout Risius Ross, LLC	Professional fees	6,000
Neal, Gerber & Eisenberg LLP	Professional fees	5,960
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 433,946

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,000
Unemployment Compensation Insurance	24,445
FICA Taxes	172,760
Employee Health Insurance	111,799
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	23,795
Covid Benefits	40,087
Employee Other Benefits	15,336
TOTAL (agree to Schedule V, line 22, col.8)	$ 490,222

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	$ 2,425
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Village of Oak Park	139
Other	1,330
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,894

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage Reimbursement	19,292
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,292

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/20 Ending: 12/31/20

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? **Yes**
If YES, give association name and amount. **HCCI $4,200**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,265** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? **X** YES ____ 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. $ **151,965**
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? **No**

(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? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.