

Facility Name & ID Number Berkeley Nrsg & Rehab Center

0050534 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,387	1,075	2,031	21,493	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,387	1,075	2,031	21,493	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.78%

D. How many bed-hold days during this year were paid by the Department? None (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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/09 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 72 and days of care provided 1,959

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number

Berkeley Nrsg & Rehab Center

0050534

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	143,550	14,678	5,907	164,135		164,135	(30)	164,105		1
2	Food Purchase		121,091		121,091		121,091		121,091		2
3	Housekeeping	87,969	11,767		99,736		99,736		99,736		3
4	Laundry	46,098	5,755		51,853		51,853		51,853		4
5	Heat and Other Utilities			94,111	94,111		94,111	781	94,892		5
6	Maintenance	30,824	4,584	33,227	68,635		68,635	259,270	327,905		6
7	Other (specify):*										7
8	TOTAL General Services	308,441	157,875	133,245	599,561		599,561	260,021	859,582		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	1,036,099	66,800	200	1,103,099		1,103,099	8,885	1,111,984		10
10a	Therapy			251,282	251,282		251,282		251,282		10a
11	Activities	50,224	2,171		52,395		52,395		52,395		11
12	Social Services	33,098		600	33,698		33,698		33,698		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy Consultant			4,542	4,542		4,542		4,542		15
16	TOTAL Health Care and Programs	1,119,421	68,971	265,024	1,453,416		1,453,416	8,885	1,462,301		16
	C. General Administration										
17	Administrative	66,429			66,429		66,429		66,429		17
18	Directors Fees										18
19	Professional Services			304,451	304,451		304,451	(265,445)	39,006		19
20	Dues, Fees, Subscriptions & Promotions			3,426	3,426		3,426	1,102	4,528		20
21	Clerical & General Office Expenses	77,286	19,033	32,539	128,858		128,858	33,130	161,988		21
22	Employee Benefits & Payroll Taxes			387,721	387,721		387,721	9,977	397,698		22
23	Inservice Training & Education										23
24	Travel and Seminar			21,465	21,465		21,465	16,770	38,235		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			275,364	275,364		275,364	75,930	351,294		26
27	Other (specify):*										27
28	TOTAL General Administration	143,715	19,033	1,024,966	1,187,714		1,187,714	(128,536)	1,059,178		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,571,577	245,879	1,423,235	3,240,691		3,240,691	140,370	3,381,061		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:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			31,411	31,411	31,411	213,416	244,827				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,911	6,911	6,911	121,597	128,508				32
33	Real Estate Taxes			136,061	136,061	136,061	78,494	214,555				33
34	Rent-Facility & Grounds			380,372	380,372	380,372	(378,722)	1,650				34
35	Rent-Equipment & Vehicles						42	42				35
36	Other (specify):*											36
37	TOTAL Ownership			554,755	554,755	554,755	34,827	589,582				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,950		57,950	57,950		57,950				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			157,967	157,967	157,967		157,967				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		57,950	157,967	215,917	215,917		215,917				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,571,577	303,829	2,135,957	4,011,363	4,011,363	175,197	4,186,560				45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	94,317	30		9
10	Interest and Other Investment Income	(77)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	1		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	(3,356)	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	(1,536)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 89,318		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	85,879	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 85,879		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 175,197		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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

BHF USE ONLY						
48		49		50		51
						52

Berkeley Nrsng & Rehab Center

ID# 0050534

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$ (105)	6	1
2	Amortization of Goodwill	(1,431)	31	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		(1,536)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Berkeley Nrsg & Rehab Center# 0050534

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	(30)	0	0	0	0	0	0	0	0	0	0	(30)	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	781	0	0	0	0	0	0	0	0	0	781	5
6	Maintenance	(105)	0	259,375	0	0	0	0	0	0	0	0	259,270	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(135)	781	259,375	0	260,021	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	8,885	0	0	0	0	0	0	0	0	0	8,885	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	8,885	0	0	0	0	0	0	0	0	0	8,885	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	(59,501)	(205,944)	0	0	0	0	0	0	0	0	(265,445)	19
20	Fees, Subscriptions & Promotions	0	27	1,075	0	0	0	0	0	0	0	0	1,102	20
21	Clerical & General Office Expenses	(3,356)	34,125	2,361	0	0	0	0	0	0	0	0	33,130	21
22	Employee Benefits & Payroll Taxes	0	9,788	189	0	0	0	0	0	0	0	0	9,977	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,448	14,322	0	0	0	0	0	0	0	0	16,770	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	25	75,905	0	0	0	0	0	0	0	0	75,930	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,356)	(13,088)	(112,092)	0	(128,536)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,491)	(3,422)	147,283	0	140,370	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Berkeley Nrsng & Rehab Center# 0050534

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	94,317	335	118,764	0	0	0	0	0	0	0	0	213,416	30
31	Amortization of Pre-Op. & Org.	(1,431)	0	1,431	0	0	0	0	0	0	0	0	0	31
32	Interest	(77)	0	121,674	0	0	0	0	0	0	0	0	121,597	32
33	Real Estate Taxes	0	0	78,494	0	0	0	0	0	0	0	0	78,494	33
34	Rent-Facility & Grounds	0	1,650	(380,372)	0	0	0	0	0	0	0	0	(378,722)	34
35	Rent-Equipment & Vehicles	0	42	0	0	0	0	0	0	0	0	0	42	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	92,809	2,027	(60,009)	0	34,827	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	89,318	(1,395)	87,274	0	0	0	0	0	0	0	0	175,197	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Joseph Blisko	99			Senior Healthcare	Skokie	Management Co
Nancy Blisko	1			JB Healthcare	Skokie	Management Co
				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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 Nursing Wages	\$	Senior Healthcare Management		\$ 8,885	\$ 8,885	1
2	V	21 Payroll		Senior Healthcare Management		33,629	33,629	2
3	V	5 Utilities		Senior Healthcare Management		781	781	3
4	V	19 Professional Services	70,000	Senior Healthcare Management		10,499	(59,501)	4
5	V	20 Licenses & Fees		Senior Healthcare Management		27	27	5
6	V	21 Office Expense		Senior Healthcare Management		496	496	6
7	V	22 Employee Benefits		Senior Healthcare Management		9,788	9,788	7
8	V	24 Travel/Seminar		Senior Healthcare Management		2,448	2,448	8
9	V	26 Insurance		Senior Healthcare Management		25	25	9
10	V	30 Depreciation Expense		Senior Healthcare Management		335	335	10
11	V	32 Interest Expense		Senior Healthcare Management				11
12	V	34 Rent Expense		Senior Healthcare Management		1,650	1,650	12
13	V	35 Equipment Lease		Senior Healthcare Management		42	42	13
14	Total		\$ 70,000			\$ 68,605	\$ * (1,395)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Repairs & Maintenance	\$	Senior Healthcare Management		\$ 6	\$	6	15
16	V	21 Office Expense		Senior Healthcare Management		1,206		1,206	16
17	V								17
18	V	6 Repairs & Maintenance		JB Healthcare		920		920	18
19	V	19 Professional Fees	212,000	JB Healthcare		1,000		(211,000)	19
20	V	21 Office Expense		JB Healthcare		459		459	20
21	V	22 Employee Benefits		JB Healthcare		189		189	21
22	V	24 Travel		JB Healthcare		14,322		14,322	22
23	V	21 Office Expense		JB Healthcare		691		691	23
24	V								24
25	V	6 Repairs & Maintenance		Woodbine Nursing Realty		258,449		258,449	25
26	V	19 Professional Fees		Woodbine Nursing Realty		5,056		5,056	26
27	V	20 Dues & Subscriptions		Woodbine Nursing Realty		1,075		1,075	27
28	V	21 Bank Service Charge		Woodbine Nursing Realty		5		5	28
29	V	26 Insurance		Woodbine Nursing Realty		75,905		75,905	29
30	V	30 Depreciation		Woodbine Nursing Realty		118,764		118,764	30
31	V	31 Amortization		Woodbine Nursing Realty		1,431		1,431	31
32	V	32 Interest		Woodbine Nursing Realty		121,674		121,674	32
33	V	33 Property Tax	136,061	Woodbine Nursing Realty		214,555		78,494	33
34	V	34 Rent	380,372	Woodbine Nursing Realty				(380,372)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 728,433			\$ 815,707	\$ *	87,274	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:

01/01/13

Ending:

12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	HUD Mortgage		X	Mortgage	\$37,689.00	8/24/12	\$ 3,614,600	\$ 3,507,190	9/1/40	2.8500	\$ 121,674						
2																	
3																	
4																	
5																	
Working Capital																	
6	Lake Forest Bank & Trust		X	Working Capital	None	8/31/11	500,000		8/31/13	5.5000	6,911						
7																	
8																	
9	TOTAL Facility Related				\$37,689.00		\$ 4,114,600	\$ 3,507,190			\$ 128,585						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 4,114,600	\$ 3,507,190			\$ 128,585						

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2012 report.		\$	52,798		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.)		\$	143,700		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	90,902		3										
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	123,653		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.		\$	214,555		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2008	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$ _____</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____														
14	PLUS APPEAL COST FROM LINE 5 \$ _____														
15	LESS REFUND FROM LINE 6 \$ _____														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____														
	2009	109,784	9												
	2010	114,812	10												
	2011	138,440	11												
	2012	143,700	12												

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.

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

01/01/13 Ending:

12/31/13

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Nursing Home</u>		<u>9/1/2009</u>	<u>\$ 250,000</u>	1
2					2
3	TOTALS			\$ 250,000	3

Facility Name & ID Number Berkeley Nrsg & Rehab Center# 0050534

Report Period Beginning:

01/01/13

Ending:

12/31/13**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	72	2009		\$ 1,050,000	\$ 26,250	39	\$ 26,923	\$ 673	\$ 113,750	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	New Roofing System	9/23/2009		53,000	1,359	39	1,359		5,831	9
10	Cabinets/Carpet Removal & Plumbing Work	10/16/2009		1,872	48	39	48		206	10
11	New Acrylic Signs	9/21/2009		1,500	38	39	38		165	11
12	Cabling for Beds & Dining Room	3/15/2010		2,000	51	39	51		177	12
13	Bathroom Remodeling, Plumbing, and Materials	3/18/2010		2,588	66	39	66		229	13
14	Sprinkler System Repairs	8/27/2010		2,821	72	39	72		250	14
15	Sprinkler System Repairs	10/7/2010		4,579	117	39	117		406	15
16	Sprinkler System Repairs	10/21/2010		1,159	30	39	30		103	16
17	Sink and Drain Repairs	1/7/2010		6,475	166	39	166		574	17
18	Replacement Chiller Coil for Air Handler Unit	6/22/2010		4,125	106	39	106		366	18
19	Chiller Coil Installation	6/23/2010		1,583	41	39	41		141	19
20	Replacement Dryer Exhaust	7/13/2010		1,000	26	39	26		89	20
21	Replacement Fire Damper Motor	8/19/2010		1,556	40	39	40		138	21
22	Heating Systems Repair	11/1/2010		2,617	67	39	67		232	22
23	Awning	4/20/2010		2,500	64	39	64		221	23
24	Sprinkler System Repairs	7/16/2011		1,800	46	39	46		113	24
25	Plumbing Work	4/21/2011		3,250	83	39	83		204	25
26	New Flooring	7/19/2011		1,440	37	39	37		91	26
27	New Locks & Handles for Doors	4/4/2012		3,800	97	39	97		134	27
28	New Handrails & Repave Parking Lot	4/4/2012		11,455	294	39	294		404	28
29	Plumbing Work & Replace Floor Tiles	6/22/2012		15,000	385	39	385		529	29
30	Install Railings & Posts	6/22/2012		5,000	128	39	128		176	30
31	Outdoor cameras	10/22/2012		19,028	3,615	39	488	(3,127)	13,129	31
32	Relocate nurses call system	12/9/2012		3,414	648	39	88	(560)	2,356	32
33	Remodel dining room, nurses station, lobby & office	8/9/2012		309,000	7,923	39	7,923		10,896	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	* Install window, handrails, stone on walls in kitchen opening,	9/25/2013	\$ 116,825	\$ 874	39	\$ 749	\$ (125)	\$ 874	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									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,629,387	\$ 42,672		\$ 39,533	\$ (3,139)	\$ 151,784	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,023,006	\$ 96,247	\$ 204,601	\$ 108,354		\$ 599,131	71
72	Current Year Purchases	21,124	11,256	693	(10,563)		11,256	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,044,130	\$ 107,503	\$ 205,294	\$ 97,791		\$ 610,387	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,923,517	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 150,175	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 244,827	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 94,652	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 762,171	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Berkeley Nrsg & Rehab Center # 0050534 Report Period Beginning: 01/01/13 Ending: 12/31/13
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$	101,401	\$		\$	101,401	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs				58,485				58,485	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a-3	hrs				91,397				91,397	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 prescripts					53,450			53,450	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Radiology & Lab</u>	39-2						4,500			4,500	12
13	Other (specify):											13
14	TOTAL			\$		\$	251,282	\$	57,950	\$	309,232	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: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	\$ 230,413	\$ 521,636	1
2	Cash-Patient Deposits	(291,496)	(291,496)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	692,321	692,321	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,178	72,178	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 703,416	\$ 994,639	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	579,387	579,387	15
16	Equipment, at Historical Cost	69,128	1,044,128	16
17	Accumulated Depreciation (book methods)	(94,995)	(765,545)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,000,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(281,630)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Escrows & Refinance</u>		105,457	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 553,520	\$ 2,981,797	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,256,936	\$ 3,976,436	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 362,717	\$ 442,087	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,796	207,796	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)	\$ 570,513	\$ 649,883	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,507,190	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,507,190	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 570,513	\$ 4,157,073	46
47	TOTAL EQUITY(page 18, line 24)	\$ 686,423	\$ (180,637)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,256,936	\$ 3,976,436	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 756,916	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 756,916	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(70,493)	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)	\$ (70,493)	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)	\$ 686,423	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,356,776	1
2	Discounts and Allowances for all Levels	127,649	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,484,425	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	414,281	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 414,281	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		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	36,459	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,557	19
20	Radiology and X-Ray	1,966	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 41,982	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	77	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 77	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	105	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 105	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,940,870	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	599,561	31
32	Health Care	1,453,416	32
33	General Administration	1,187,714	33
B. Capital Expense			
34	Ownership	554,755	34
C. Ancillary Expense			
35	Special Cost Centers	57,950	35
36	Provider Participation Fee	157,967	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,011,363	40
41	Income before Income Taxes (line 30 minus line 40)**	(70,493)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (70,493)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,660,913	44
45	Private Pay - Net Inpatient Revenue	261,799	45
46	Medicare - Net Inpatient Revenue	415,946	46
47	Other-(specify)	145,767	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,484,425	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:

01/01/13

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,723	1,912	\$ 75,783	\$ 39.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,026	3,316	108,541	32.73	3
4	Licensed Practical Nurses	14,467	15,419	400,094	25.95	4
5	CNAs & Orderlies	31,789	33,968	376,926	11.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,792	4,110	50,224	12.22	9
10	Activity Assistants					10
11	Social Service Workers	1,874	2,108	33,098	15.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,980	13,133	143,550	10.93	15
16	Dishwashers					16
17	Maintenance Workers	2,115	2,182	30,824	14.13	17
18	Housekeepers	8,717	9,114	87,969	9.65	18
19	Laundry	4,049	4,523	46,098	10.19	19
20	Administrator	1,750	1,938	66,429	34.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,125	6,310	77,286	12.25	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	901	1,000	15,788	15.79	31
32	Other Health C: <u>MDS</u>	1,764	1,935	58,967	30.47	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	94,072	100,968	\$ 1,571,577 *	\$ 15.57	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	169	\$ 5,907	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	6	200	10-3	38
39	Pharmacist Consultant	91	4,542	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	17	600	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	283	\$ 11,249		49

C. CONTRACT NURSES

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

Facility Name & ID Number Berkeley Nrsg & Rehab Center

0050534

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Michael Gottesman	Admin		\$ 66,429	Workers' Compensation Insurance	\$ 55,414	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	214,018	Health Care Worker Background Check		
				Employee Health Insurance	103,903	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Village of Oak Park	1,371	
				Pension Expense	4,902	Cook County Collector	168	
				Employee Expense	19,129	State Fire Marshall	280	
				Education & Seminar	332	CMS	532	
						Other License and Dues	2,177	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 66,429	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 397,698		\$ 4,528		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	
(Attach a copy of any management service agreement)								
C. Professional Services							In-State Travel	
Vendor/Payee	Type		Amount				Auto Allowance	9,346
JB Healthcare	Management Fees		\$ 212,000				Mileage	11,973
Peckar & Abramson	Legal		5,676				Patient Transport	146
Bradley Associates	Accounting		11,905				Seminar Expense	
Senior Healthcare	Accounting		70,000				JB Healthcare Travel	14,322
Alan Irni	Accounting		500				Management Lodging and gasoline	2,448
MTS Consulting	Professional Fees		4,370				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 38,235
TOTAL (agree to Schedule V, line 19, column 3)			\$ 304,451					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Berkeley Nrsg & Rehab Center# 0050534

Report Period Beginning:

01/01/13

Ending:

12/31/13**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. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,028 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 157,967
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.