

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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

<p>I. IDPH License ID Number: <u>0050534</u></p> <p>Facility Name: <u>Berkeley Nursing and Rehabilitation Center</u></p> <p>Address: <u>6909 West North Avenue</u> <u>Oak Park</u> <u>60302</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>708-236-0000</u> Fax # <u>708-236-0001</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>9/1/09</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Daniel S. Gaafar</u> Telephone Number: <u>317-237-5500</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Alan Irni</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>CFO</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN 46225</u></td> </tr> <tr> <td>(Telephone) <u>317-237-5500</u> Fax # <u>317-237-5503</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Alan Irni</u> (Date) _____		(Title) <u>CFO</u>	Paid Preparer	(Signed) _____	(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u>	(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN 46225</u>	(Telephone) <u>317-237-5500</u> Fax # <u>317-237-5503</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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Facility Name & ID Number Berkeley Nursing and Rehabilitation Center

0050534 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	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	19,913	676	1,730	22,319	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,913	676	1,730	22,319	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.93%

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)
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 9/1/09

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 72 and days of care provided 1,372

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Berkeley Nursing and Rehabilitation Center # 0050534 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	152,018	14,523	7,408	173,949		173,949		173,949		1
2	Food Purchase		138,460		138,460		138,460	(21)	138,439		2
3	Housekeeping	141,897	15,916		157,813		157,813		157,813		3
4	Laundry	25,793	5,709		31,502		31,502		31,502		4
5	Heat and Other Utilities			103,353	103,353		103,353	1,136	104,489		5
6	Maintenance	33,409	5,922	50,323	89,654		89,654	69,696	159,350		6
7	Other (specify):*										7
8	TOTAL General Services	353,117	180,530	161,084	694,731		694,731	70,811	765,542		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	1,230,076	67,647		1,297,723		1,297,723		1,297,723		10
10a	Therapy			326,663	326,663		326,663		326,663		10a
11	Activities	101,001	5,033		106,034		106,034		106,034		11
12	Social Services	39,495		671	40,166		40,166		40,166		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy Consultant			6,949	6,949		6,949		6,949		15
16	TOTAL Health Care and Programs	1,370,572	72,680	342,683	1,785,935		1,785,935		1,785,935		16
	C. General Administration										
17	Administrative	82,179			82,179		82,179		82,179		17
18	Directors Fees										18
19	Professional Services			437,654	437,654		437,654	(398,937)	38,717		19
20	Dues, Fees, Subscriptions & Promotions			2,121	2,121		2,121	299	2,420		20
21	Clerical & General Office Expenses	119,412	19,306	32,637	171,355		171,355	78,550	249,905		21
22	Employee Benefits & Payroll Taxes			402,266	402,266		402,266	6,364	408,630		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,474	9,474		9,474	28,490	37,964		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			430,676	430,676		430,676	250,146	680,822		26
27	Other (specify):*										27
28	TOTAL General Administration	201,591	19,306	1,314,828	1,535,725		1,535,725	(35,088)	1,500,637		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,925,280	272,516	1,818,595	4,016,391		4,016,391	35,723	4,052,114		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 Nursing and Rehabilitation Center

#0050534

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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			31,276	31,276		31,276	49,351	80,627			30
31	Amortization of Pre-Op. & Org.							67,812	67,812			31
32	Interest			25,454	25,454		25,454	102,607	128,061			32
33	Real Estate Taxes			232,441	232,441		232,441	(23,613)	208,828			33
34	Rent-Facility & Grounds			329,685	329,685		329,685	(324,842)	4,843			34
35	Rent-Equipment & Vehicles							478	478			35
36	Other (specify):*											36
37	TOTAL Ownership			618,856	618,856		618,856	(128,207)	490,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,574		44,574		44,574		44,574			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,641	166,641		166,641		166,641			42
43	Other (specify):* Bad Debt			257,794	257,794		257,794	257,794	515,588			43
44	TOTAL Special Cost Centers		44,574	424,435	469,009		469,009	257,794	726,803			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,925,280	317,090	2,861,886	5,104,256		5,104,256	165,310	5,269,566			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	22,429	30		9
10	Interest and Other Investment Income	(2,570)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	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	257,794	43		24
25	Fund Raising, Advertising and Promotional	(3,407)	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	(1,012)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 271,783		\$	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)	(106,473)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (106,473)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 165,310		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	
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Berkeley Nursing and Rehabilitation Center

ID# 0050534

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$	(1,012)	21
2				
3				
4				
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48				
49	Total		(1,012)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Berkeley Nursing and Rehabilitation Center# 0050534

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(21)	0	0	0	0	0	0	0	0	0	0	(21)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,136	0	0	0	0	0	0	0	0	0	1,136	5
6	Maintenance	0	145	69,551	0	0	0	0	0	0	0	0	69,696	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(21)	1,281	69,551	0	70,811	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(104,087)	(294,850)	0	0	0	0	0	0	0	0	(398,937)	19
20	Fees, Subscriptions & Promotions	0	49	250	0	0	0	0	0	0	0	0	299	20
21	Clerical & General Office Expenses	(5,849)	84,331	68	0	0	0	0	0	0	0	0	78,550	21
22	Employee Benefits & Payroll Taxes	0	6,364	0	0	0	0	0	0	0	0	0	6,364	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,578	25,912	0	0	0	0	0	0	0	0	28,490	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	11	250,135	0	0	0	0	0	0	0	0	250,146	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(5,849)	(10,754)	(18,485)	0	(35,088)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,870)	(9,473)	51,066	0	35,723	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Berkeley Nursing and Rehabilitation Center # 0050534 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	22,429	0	26,922	0	0	0	0	0	0	0	0	49,351	30
31	Amortization of Pre-Op. & Org.	0	0	67,812	0	0	0	0	0	0	0	0	67,812	31
32	Interest	(2,570)	0	105,177	0	0	0	0	0	0	0	0	102,607	32
33	Real Estate Taxes	0	0	(23,613)	0	0	0	0	0	0	0	0	(23,613)	33
34	Rent-Facility & Grounds	0	4,843	(329,685)	0	0	0	0	0	0	0	0	(324,842)	34
35	Rent-Equipment & Vehicles	0	478	0	0	0	0	0	0	0	0	0	478	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	19,859	5,321	(153,387)	0	(128,207)	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):*	257,794	0	0	0	0	0	0	0	0	0	0	257,794	43
44	TOTAL Special Cost Centers	257,794	0	0	0	0	0	0	0	0	0	0	257,794	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	271,783	(4,152)	(102,321)	0	165,310	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			JB Healthcare	Skokie	Mgmt Co.
Nancy Blisko	1			Woodbine Realty	Oak Park	Realty Co.
				Senior Healthcare	Skokie	Mgmt Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	5 Utilities	\$	Senior Healthcare Management		\$ 1,136	\$ 1,136	1
2	V	6 Repairs		Senior Healthcare Management		145	145	2
3	V	19 Professional Services	104,250	Senior Healthcare Management		163	(104,087)	3
4	V	20 Licenses & Fees		Senior Healthcare Management		49	49	4
5	V	21 Office Supplies		Senior Healthcare Management		1,637	1,637	5
6	V	21 Office Expense		Senior Healthcare Management		506	506	6
7	V	21 Payroll		Senior Healthcare Management		82,188	82,188	7
8	V	22 Employee Benefits		Senior Healthcare Management		6,364	6,364	8
9	V	24 Travel/Seminar		Senior Healthcare Management		2,578	2,578	9
10	V	26 Insurance		Senior Healthcare Management		11	11	10
11	V	34 Rent Expense		Senior Healthcare Management		4,843	4,843	11
12	V	35 Equipment Lease		Senior Healthcare Management		478	478	12
13	V							13
14	Total		\$ 104,250			\$ 100,098	\$ * (4,152)	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	19 Professional Fees	\$ 300,000	JB Healthcare		\$ 250	\$ (299,750)
16	V	21 Office Supplies		JB Healthcare		53	53
17	V	24 Travel		JB Healthcare		25,912	25,912
18	V	32 Interest		JB Healthcare		19	19
19	V						
20	V	6 Repairs & Maintenance		Woodbine Nursing Realty		69,551	69,551
21	V	19 Professional Fees		Woodbine Nursing Realty		4,900	4,900
22	V	20 Dues & Subscriptions		Woodbine Nursing Realty		250	250
23	V	21 Office Expense		Woodbine Nursing Realty		15	15
24	V	26 Insurance		Woodbine Nursing Realty		250,135	250,135
25	V	30 Depreciation		Woodbine Nursing Realty		26,922	26,922
26	V	31 Amortization		Woodbine Nursing Realty		67,812	67,812
27	V	32 Interest		Woodbine Nursing Realty		105,158	105,158
28	V	33 Property Tax	232,441	Woodbine Nursing Realty		208,828	(23,613)
29	V	34 Rent	329,685	Woodbine Nursing Realty			(329,685)
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 862,126			\$ 759,805	\$ * (102,321)

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

Facility Name & ID Number Berkeley Nursing and Rehabilitation Center # 0050534 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Nursing and Rehabilitation Center # 0050534 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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

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	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

Facility Name & ID Number

Berkeley Nursing and Rehabilitation Center

0050534

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	HUD Mortgage		X	Mortgage	\$61,634.00	8/24/12	\$ 3,614,600	\$ 3,136,627	9/1/40	2.8500	\$ 105,177	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Lake Forest Bank & Trust		X	Working Capital	None	8/31/17	800,000	550,000	8/31/18	5.7500	22,884	6								
7												7								
8												8								
9	TOTAL Facility Related				\$61,634.00		\$ 4,414,600	\$ 3,686,627			\$ 128,061	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	\$ 3,686,627			\$ 128,061	15								

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

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

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

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 2016 report.		\$	453,644	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.)		\$	208,702	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(244,942)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	453,770	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.		\$	208,828	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	143,700	8	
	2013	143,746	9	
	2014	173,763	10	
	2015	186,995	11	
	2016	208,702	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.

Facility Name & ID Number Berkeley Nursing and Rehabilitation Center

0050534 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

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).

None

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

Facility Name & ID Number Berkeley Nursing and Rehabilitation Center# 0050534

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**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	\$ 26,922	39	\$ 26,923	\$ 1	\$ 141,344	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		11,293	9
10		Cabinets/Carpet Removal & Plumbing Work	10/16/2009		1,872	48	39	48		383	10
11		New Acrylic Signs	9/21/2009		1,500	38	39	38		306	11
12		Cabling for Beds & Dining Room	3/15/2010		2,000	51	39	51		402	12
13		Bathroom Remodeling, Plumbing, and Materials	3/18/2010		2,588	66	39	66		520	13
14		Sprinkler System Repairs	8/27/2010		2,821	72	39	72		536	14
15		Sprinkler System Repairs	10/7/2010		4,579	117	39	117		851	15
16		Sprinkler System Repairs	10/21/2010		1,159	30	39	30		215	16
17		Sink and Drain Repairs	1/7/2010		6,475	166	39	166		1,210	17
18		Replacement Chiller Coil for Air Handler Unit	6/22/2010		4,125	106	39	106		802	18
19		Chiller Coil Installation	6/23/2010		1,583	41	39	41		308	19
20		Replacement Dryer Exhaust	7/13/2010		1,000	26	39	26		192	20
21		Replacement Fire Damper Motor	8/19/2010		1,556	40	39	40		296	21
22		Heating Systems Repair	11/1/2010		2,617	67	39	67		481	22
23		Awning	4/20/2010		2,500	64	39	64		497	23
24		Sprinkler System Repairs	7/16/2011		1,800	46	39	46		300	24
25		Plumbing Work	4/21/2011		3,250	83	39	83		533	25
26		New Flooring	7/19/2011		1,440	37	39	37		240	26
27		High resolution outdoor cameras	10/22/2012		19,028	781	39	781		18,637	27
28		Relocate nurses call system	12/9/2012		3,414	140	39	140		3,344	28
29		Provide door hardware	4/4/2012		3,800	97	39	97		560	29
30		Remove and repair handrails	4/4/2012		11,455	294	39	294		1,689	30
31		Renovation of bathroom	6/22/2012		20,000	513	39	513		2,863	31
32		Integra Development	8/9/2012		309,000	7,923	39	7,923		42,335	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 Nursing and Rehabilitation Center# 0050534

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**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	\$ 2,996	39	\$ 2,996	\$	\$ 12,857	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 - ceiling tiles, handrail, carpet, cove base, paint,								44
45	door casing, vinyl sheets, laminate walls, floor prep, signage,								45
46	lighting, electrical 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		15,782	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		435	53
54									54
55	Flooring in resident rooms, cove base, wall coverings, painting,	5/15/2015	44,407	1,139	39	1,139		2,799	55
56	electrical, new closet dividers, ceiling tiles, plumbing in bathrooms								56
57	Tile and grout in bathrooms								57
58									58
59	Replace 10' of cast iron plumbing pipe	2016	1,950	50	39	50		73	59
60	Wall coverings, light fix, tile, electrical work in resident rooms	2016	24,697	633	39	633		923	60
61	New pit ladder installation	2016	2,801	72	39	72		105	61
62	Replace mixing valve	2016	3,272	84	39	84		122	62
63	Laundry fan replacement	2016	2,350	60	39	60		88	63
64	New water heater	2016	4,413	113	39	113		165	64
65	New roof fan	2016	5,200	133	39	133		194	65
66	New A/C blower motor	2016	1,292	33	39	33		48	66
67	New fan vent	2016	950	24	39	24		35	67
68	New fire panel board	2016	2,475	63	39	63		92	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,882,994	\$ 48,626		\$ 48,627	\$ 1	\$ 263,858	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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	\$ 48,626		\$ 48,627	\$ 1	\$ 263,858	1
2	Replace existing outdoor carpet, debris container and	2016	108,800	2,790	39	2,790		4,069	2
3	removal, removal of existing floor and wall tiles in 11								3
4	resident rooms								4
5									5
6	Renovate shower room	2017	17,986	231	39	231		231	6
7	New compressor	2017	10,500	135	39	135		135	7
8	New sidewalk	2017	8,100	104	39	104		104	8
9	Cooling tower and building circulation pump	2017	6,300	81	39	81		81	9
10									10
11	New elevator door	2017	3,800	49	39	49		49	11
12	Electrical work in patient care areas	2017	28,450	365	39	365		365	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,066,929	\$ 52,379		\$ 52,380	\$ 1	\$ 268,890	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 133,751	\$ 4,322	\$ 26,750	\$ 22,428	5	\$ 170,104	71
72	Current Year Purchases	14,973	1,497	1,497		5	1,497	72
73	Fully Depreciated Assets	975,000				5	975,000	73
74								74
75	TOTALS	\$ 1,123,724	\$ 5,819	\$ 28,247	\$ 22,428		\$ 1,146,601	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)	\$ 3,440,653	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,198	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 80,627	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,429	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,415,491	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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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		\$	1,912	\$ 125,248	\$	1,912	\$	125,248					1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			1,490	64,746		1,490		64,746					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs			2,063	136,670		2,063		136,670					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							41,375					41,375	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Xray & Lab</u>	39-2								3,199					3,199	12
13	Other (specify):															13
14	TOTAL				\$	5,465	\$ 326,664	\$	5,465	\$	44,574	\$	5,465	\$	371,238	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 Nursing and Rehabilitation Center**# **0050534**Report Period Beginning: **1/1/2017**Ending: **12/31/2017****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 70,462	\$ 235,467	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,352,814	1,423,892	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	151,039	151,039	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Replacement Reserve	(397,054)	(329,202)	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,177,261	\$ 1,481,196	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	1,000,736	1,000,736	15
16	Equipment, at Historical Cost	164,918	1,139,918	16
17	Accumulated Depreciation (book methods)	(234,985)	(1,415,491)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,000,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(618,409)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		174,520	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 930,669	\$ 2,581,274	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,107,930	\$ 4,062,470	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 734,706	\$ 955,206	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,494	174,494	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	13,349	13,349	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)	\$ 922,549	\$ 1,143,049	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	550,000	550,000	39
40	Mortgage Payable		3,136,627	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)	\$ 550,000	\$ 3,686,627	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,472,549	\$ 4,829,676	46
47	TOTAL EQUITY(page 18, line 24)	\$ 635,381	\$ (767,206)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,107,930	\$ 4,062,470	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,068,589	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,068,589	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(433,205)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (433,208)	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)	\$ 635,381	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Berkeley Nursing and Rehabilitation Center

0050534

Report Period Beginning: 1/1/2017

Ending:

12/31/2017

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,523,099	1
2	Discounts and Allowances for all Levels	(533,515)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,989,584	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	635,209	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 635,209	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	24,970	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	17,706	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 42,676	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,570	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,570	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	1,012	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,012	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,671,051	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	694,731	31
32	Health Care	1,785,935	32
33	General Administration	1,535,725	33
B. Capital Expense			
34	Ownership	618,856	34
C. Ancillary Expense			
35	Special Cost Centers	44,574	35
36	Provider Participation Fee	166,641	36
D. Other Expenses (specify):			
37	Bad Debt Expense	257,794	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,104,256	40
41	Income before Income Taxes (line 30 minus line 40)**	(433,205)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (433,205)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,813,923	44
45	Private Pay - Net Inpatient Revenue	158,725	45
46	Medicare - Net Inpatient Revenue	738,540	46
47	Other-(specify)	278,396	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,989,584	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 Nursing and Rehabilitation Center

0050534

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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	1,959	2,100	\$ 85,176	\$ 40.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,840	6,331	202,867	32.04	3
4	Licensed Practical Nurses	15,071	16,113	437,466	27.15	4
5	CNAs & Orderlies	38,508	40,927	489,157	11.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,619	8,490	101,001	11.90	9
10	Activity Assistants					10
11	Social Service Workers	1,977	2,270	39,495	17.40	11
12	Dietician	12,233	12,952	152,018	11.74	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,895	2,103	33,409	15.89	17
18	Housekeepers	12,909	13,639	141,897	10.40	18
19	Laundry	2,201	2,471	25,793	10.44	19
20	Administrator	1,958	2,137	82,179	38.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,577	5,987	66,008	11.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,204	1,374	15,410	11.22	31
32	Other Health C: <u>Admission Cord</u>	2,170	2,221	53,404	24.05	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	111,121	119,115	\$ 1,925,280 *	\$ 16.16	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	212	\$ 7,408	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	139	6,949	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	19	671	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	370	\$ 15,028		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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,323 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 166,641
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? 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