

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: <u>0050534</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Berkeley Nursing and Rehabilitation Center, LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/11</u> to <u>12/31/11</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>6909 West North Avenue</u> <u>Oak Park</u> <u>60302</u>			
NumberCityZip Code			
County: <u>Cook</u>			
Telephone Number: <u>(708) 236-0000</u> Fax # <u>(708) 236-0001</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>9/1/09</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____			
☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other _____			
☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____			
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: _____			
		Officer or Administrator of Provider Paid Preparer (Signed) _____ (Type or Print Name) <u>Joseph Blisko</u> (Title) <u>Manager</u> (Signed) <u>See Accountants' Compilation Report Attached</u> (Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u> (Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Avenue, Suite 910, Indianapolis, IN 46225</u> (Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>	
		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkeley Nursing and Rehabilitation Center, LLC

0050534 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	<u>72</u>	Skilled (SNF)	<u>72</u>	<u>26,280</u>	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	<u>72</u>	TOTALS	<u>72</u>	<u>26,280</u>	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	<u>15,365</u>	<u>1,521</u>	<u>3,540</u>	<u>20,426</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,365</u>	<u>1,521</u>	<u>3,540</u>	<u>20,426</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.72%

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 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 66 and days of care provided 3,086

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Berkeley Nursing and Rehabilitation Center, # 0050534 Report Period Beginning: 1/1/11 Ending: 12/31/11
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	146,876	14,526	6,847	168,249		168,249	(39)	168,210			1
2	Food Purchase		106,668		106,668		106,668		106,668			2
3	Housekeeping	78,877	12,702		91,579		91,579		91,579			3
4	Laundry	49,704	11,155		60,859		60,859		60,859			4
5	Heat and Other Utilities			93,295	93,295		93,295	1,402	94,697			5
6	Maintenance	35,597	8,299	36,441	80,337		80,337	3,553	83,890			6
7	Other (specify):*											7
8	TOTAL General Services	311,054	153,350	136,583	600,987		600,987	4,916	605,903			8
	B. Health Care and Programs											
9	Medical Director			9,500	9,500		9,500		9,500			9
10	Nursing and Medical Records	955,619	68,858	4,077	1,028,554		1,028,554	6,704	1,035,258			10
10a	Therapy			295,869	295,869		295,869		295,869			10a
11	Activities	73,151	5,841		78,992		78,992		78,992			11
12	Social Services	17,796		1,998	19,794		19,794		19,794			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			1,874	1,874		1,874		1,874			15
16	TOTAL Health Care and Programs	1,046,566	74,699	313,318	1,434,583		1,434,583	6,704	1,441,287			16
	C. General Administration											
17	Administrative	66,876			66,876		66,876		66,876			17
18	Directors Fees											18
19	Professional Services			237,216	237,216		237,216	(138,760)	98,456			19
20	Dues, Fees, Subscriptions & Promotions			5,209	5,209		5,209	162	5,371			20
21	Clerical & General Office Expenses	68,044	24,494	6,243	98,781		98,781	26,661	125,442			21
22	Employee Benefits & Payroll Taxes			358,165	358,165		358,165	5,186	363,351			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,520	19,520		19,520	6,932	26,452			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,369	57,369		57,369	1,078	58,447			26
27	Other (specify):*											27
28	TOTAL General Administration	134,920	24,494	683,722	843,136		843,136	(98,741)	744,395			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,492,540	252,543	1,133,623	2,878,706		2,878,706	(87,121)	2,791,585			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			25,731	25,731		25,731	204,538	230,269			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,633	5,633		5,633	179,651	185,284			32
33	Real Estate Taxes							108,213	108,213			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(533,852)	6,148			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			571,364	571,364		571,364	(41,450)	529,914			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		104,419		104,419		104,419		104,419			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,571	40,571		40,571		40,571			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		104,419	40,571	144,990		144,990		144,990			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,492,540	356,962	1,745,558	3,595,060		3,595,060	(128,571)	3,466,489			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	87,569	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	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	(1,070)	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	(87,617)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,157)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(127,414)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (127,414)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (128,571)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning: ID# 0050534

Ending: 1/1/11

12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Vending Income	\$ (767)	6	1
2	Miscellaneous Income	(1,350)	21	2
3	Amortization of Goodwill	(85,500)	30	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	(87,617)		49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

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	Parker Nursing & Rehab	Streator	Senior Healthcare	Skokie	Management Co
Nancy Blisko	1			JB Healthcare	Skokie	Management Co
				Woodbine Nrsg 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	21	Payroll	\$	Senior Healthcare Management		\$ 23,734	\$ 23,734	1
2	V	5	Utilities		Senior Healthcare Management		748	748	2
3	V	19	Professional Services		Senior Healthcare Management		4,805	4,805	3
4	V	20	Licenses & Fees		Senior Healthcare Management		37	37	4
5	V	21	Office Expense		Senior Healthcare Management		417	417	5
6	V	22	Employee Benefits		Senior Healthcare Management		5,186	5,186	6
7	V	24	Travel/Seminar		Senior Healthcare Management		1,323	1,323	7
8	V	26	Insurance		Senior Healthcare Management		83	83	8
9	V	30	Depreciation Expense		Senior Healthcare Management		338	338	9
10	V	32	Interest Expense		Senior Healthcare Management		63	63	10
11	V	34	Rent Expense		Senior Healthcare Management		1,148	1,148	11
12	V	6	Repairs & Maintenance		Senior Healthcare Management		4	4	12
13	V	21	Office Expense		Senior Healthcare Management		1,682	1,682	13
14	Total			\$			\$ 39,568	\$ * 39,568	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	10	Nursing Wages	\$	Senior Healthcare Management		\$ 6,704	\$ 6,704	15
16	V								16
17	V	5	Telephone		JB Healthcare		654	654	17
18	V	6	Repairs & Maintenance		JB Healthcare		4,316	4,316	18
19	V	19	Professional Fees	145,750	JB Healthcare		1,250	(144,500)	19
20	V	20	Dues & Subscriptions		JB Healthcare		125	125	20
21	V	21	Office Expense		JB Healthcare		452	452	21
22	V	24	Travel		JB Healthcare		5,609	5,609	22
23	V	26	Insurance		JB Healthcare		995	995	23
24	V	34	Rent		JB Healthcare		5,000	5,000	24
25	V	21	Office Supplies		JB Healthcare		2,796	2,796	25
26	V								26
27	V	19	Legal & Professional		Woodbine Nursing Realty		935	935	27
28	V	30	Depreciation		Woodbine Nursing Realty		202,131	202,131	28
29	V	32	Interest	30,974	Woodbine Nursing Realty		210,562	179,588	29
30	V	33	Property Taxes	6,609	Woodbine Nursing Realty		114,822	108,213	30
31	V	34	Rent	540,000	Woodbine Nursing Realty			(540,000)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 723,333			\$ 556,351	\$ * (166,982)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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, LLC # 0050534 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

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	Lake Forest Bank & Trust		X	Mortgage		9/1/2009	\$ 2,700,000	\$ 2,609,099	10/10/2034	0.0675	\$ 179,588	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Lake Forest Bank & Trust		X	Working Capital		8/31/2011	500,000	250,000	8/31/2012	5.5000	5,633	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 3,200,000	\$ 2,859,099			\$ 185,221	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,200,000	\$ 2,859,099			\$ 185,221	15	

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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	4,003	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.)				\$	114,812	2
3. Under or (over) accrual (line 2 minus line 1).				\$	110,809	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	(1,526)	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.				\$	109,283	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2006		8			
	2007		9			
	2008		10			
	2009	109,784	11			
	2010	114,812	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

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Berkeley Nursing and Rehabilitation Center, LLC</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0050534</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Daniel S. Gaafar</u>		
TELEPHONE	<u>(317) 237-5500</u>	FAX #:	<u>(317) 237-5503</u>

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

YES	X	NO
-----	---	----

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

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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: 46,282

2. Number of Years Over Which it is Being Amortized: 5 years

3. Current Period Amortization: 4,445

4. Dates Incurred: Prior to 9/1/09

Nature of Costs: Organizational 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 Home</u>		<u>9/1/2009</u>	<u>\$ 250,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			<u>\$ 250,000</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 26,722	39	\$ 26,722		\$ 62,818
5										
6										
7										
8										
	Improvement Type**									
9	New Roofing System			9/23/2009	53,000	1,359	39	1,359		6,150
10	Cabinets/Carpet Removal & Plumbing Work			10/16/2009	1,872	48	39	48		144
11	New Acrylic Signs			9/21/2009	1,500	38	39	38		115
12	Cabling for Beds & Dining Room			3/15/2010	2,000	51	39	51		103
13	Bathroom Remodeling, Plumbing, and Materials			3/18/2010	2,588	66	39	66		133
14	Sprinkler System Repairs			8/27/2010	2,821	72	39	72		145
15	Sprinkler System Repairs			10/7/2010	4,579	117	39	117		235
16	Sprinkler System Repairs			10/21/2010	1,159	30	39	30		59
17	Sink and Drain Repairs			1/7/2010	6,475	166	39	166		332
18	Replacement Chiller Coil for Air Handler Unit			6/22/2010	4,125	106	39	106		212
19	Chiller Coil Installation			6/23/2010	1,583	41	39	41		81
20	Replacement Dryer Exhaust			7/13/2010	1,000	26	39	26		51
21	Replacement Fire Damper Motor			8/19/2010	1,556	40	39	40		80
22	Heating Systems Repair			11/1/2010	2,617	67	39	67		134
23	Awning			4/20/2010	2,500	64	39	64		128
24	Sprinkler System Repairs			7/16/2011	1,800	19	39	19		19
25	Plumbing Work			4/21/2011	3,250	41	39	41		41
26	New Flooring			7/19/2011	1,440	15	39	15		15
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

XI. OWNERSHIP COSTS (continued)

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

1		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			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									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)		\$1,145,865	\$29,089		\$29,089	\$	\$70,995	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$993,350	\$90,511	\$198,670	\$108,159	5	\$284,031	71
72	Current Year Purchases	18,117	18,117	2,510	(15,607)	5	18,117	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,011,467	\$108,628	\$201,180	\$92,552		\$302,148	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	2	
	Reference	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)	\$2,407,332	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$137,717	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$230,269	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$92,552	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$373,143	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: Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	104,811	\$		\$	104,811	1			
2	Licensed Speech and Language Development Therapist		hrs				78,357				78,357	2			
3	Licensed Recreational Therapist		hrs									3			
4	Licensed Physical Therapist		hrs				112,701				112,701	4			
5	Physician Care		visits									5			
6	Dental Care		visits									6			
7	Work Related Program		hrs									7			
8	Habilitation		hrs									8			
9	Pharmacy		# of prescrpts					97,321			97,321	9			
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)														
10			hrs									10			
11	Academic Education		hrs									11			
12	Other (specify):											12			
13	Other (specify): Radiology & Lab							7,098			7,098	13			
14	TOTAL			\$		\$	295,869	\$	104,419	\$	400,288	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 137,614	\$ 234,272	1
2	Cash-Patient Deposits	(7,351)	(7,351)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,187,353	1,187,353	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,381	333,381	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)	\$ 1,400,997	\$ 1,747,655	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		1,050,000	14
15	Leasehold Improvements, at Historical Cost	95,865	95,865	15
16	Equipment, at Historical Cost	36,466	1,011,466	16
17	Accumulated Depreciation (book methods)	(36,029)	(373,143)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,046,282	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(215,601)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Security Deposit	7,123	7,123	22
23	Other(specify): Tax Escrow & Refinance		243,860	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 103,425	\$ 2,865,852	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,504,422	\$ 4,613,507	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 437,515	\$ 437,515	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	179,083	179,083	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		72,845	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capial Note	250,000	700,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 866,598	\$ 1,389,443	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,609,099	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,609,099	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 866,598	\$ 3,998,542	46
47	TOTAL EQUITY(page 18, line 24)	\$ 637,824	\$ 614,965	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,504,422	\$ 4,613,507	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 269,547	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 269,547	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	370,417	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) FY 2010 Adjustments	(2,140)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 368,277	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)	\$ 637,824	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,748,600	1
2	Discounts and Allowances for all Levels	168,347	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,916,947	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	34,306	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 34,306	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	11,284	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	376	19
20	Radiology and X-Ray	447	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,107	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	767	28
28a	<u>Miscellaneous Income</u>	1,350	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,117	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,965,477	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	600,987	31
32	Health Care	1,434,583	32
33	General Administration	843,136	33
	B. Capital Expense		
34	Ownership	571,364	34
	C. Ancillary Expense		
35	Special Cost Centers	104,419	35
36	Provider Participation Fee	40,571	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,595,060	40
41	Income before Income Taxes (line 30 minus line 40)**	370,417	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 370,417	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,924	2,054	\$ 73,034	\$ 35.56	1
2	Assistant Director of Nursing	1,783	1,915	54,864	28.65	2
3	Registered Nurses	3,204	3,253	98,620	30.32	3
4	Licensed Practical Nurses	13,124	13,804	355,384	25.75	4
5	CNAs & Orderlies	32,264	34,286	372,064	10.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,555	6,101	73,151	11.99	9
10	Activity Assistants					10
11	Social Service Workers	1,248	1,424	17,796	12.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,848	13,861	146,876	10.60	15
16	Dishwashers					16
17	Maintenance Workers	2,792	2,880	35,597	12.36	17
18	Housekeepers	7,929	8,475	78,877	9.31	18
19	Laundry	5,295	5,667	49,704	8.77	19
20	Administrator	2,042	2,164	66,876	30.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,346	6,931	68,044	9.82	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	144	149	1,653	11.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,498	102,964	\$ 1,492,540 *	\$ 14.50	34

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	196	\$ 6,847	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	116	4,077	10-3	38
39	Pharmacist Consultant	37	1,874	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	57	1,998	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	406	\$ 14,796		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberBerkeley Nursing and Rehabilitation Center, LLC# 0050534Report Period Beginning:1/1/11Ending:12/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eli Barnett	Admin		\$ 4,039
Michael Gottesman	Admin		62,837
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,876

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JB Healthcare	Management Fees	\$ 145,750
Skidelsky & Associates	Legal	20,907
Bradely Associates	Accounting	15,759
Senior Healthcare	Accounting	48,000
Alan J. Irni	Accounting	1,800
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 232,216

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 42,636	
Unemployment Compensation Insurance	95,855	
FICA Taxes	118,092	
Employee Health Insurance	88,209	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Pension Expense	12,191	
Employee Expense	6,368	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 363,351

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$ 1,990	
Advertising: Employee Recruitment		
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks		
Cook Co Collector	168	
Oak Park River Forest Dues	395	
State Fire Marshall	210	
Village of Oak Park	2,446	
Other License and Dues	162	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,371

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Auto Allowance	4,385
Mileage	14,085
Senior Healthcare Travel	1,323
Seminar Expense	
Travel/Seminar	1,050
JB Travel	5,609
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 26,452

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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?
If YES, give association name and amount.

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

NO
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$16,902

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

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

NO
- (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)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES

NO

X
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$40,571
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO
- (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?
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.

N/A
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$NONE

N/A

Indicate the amount. \$N/A
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO

N/A
- (17) Has an audit been performed by an independent certified public accounting firm?
Firm Name:

NO

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?
Attach invoices and a summary of services for all architect and appraisal fees.

Yes

SEE ACCOUNTANTS' COMPILATION REPORT