FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0050534

Facility Name: Berkeley Nrsg Rehab Center

Address: 6909 West North Ave (Number) Oak Park (City) 60302 (Zip Code)

County: Cook

Telephone Number: 708-236-0000 **Fax #** 708-236-0001

HFS ID Number:

Date of Initial License for Current Owners: 9/1/2009

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: DANIEL GAAFAR **Telephone Number:** 317-237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/25 to 12/31/25 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) ALAN IRNI
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY AND ASSOCIATES, 201 S. CAPITOL, STE 700, INDIANAPOLIS, IN 46225
(Telephone) 317-237-5500 Fax # 317-237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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 72

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF	4,651	8,709	1,737	196	1,114	1,334	229	17,970	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,651	8,709	1,737	196	1,114	1,334	229	17,970	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 68.38%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/01/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 72

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	320,112	213	16,319	336,644		336,644		336,644			1
2	Food Purchase		203,433		203,433		203,433	26	203,459			2
3	Housekeeping	74,456	13,816		88,272		88,272		88,272			3
4	Laundry	75,694	4,783		80,477		80,477		80,477			4
5	Heat and Other Utilities			94,041	94,041		94,041	944	94,985			5
6	Maintenance	52,744	48,660		101,404		101,404	3,987	105,391			6
7	Other (specify):*											7
8	**TOTAL General Services**	523,006	270,905	110,360	904,271		904,271	4,957	909,228			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,909,087	132,717		2,041,804		2,041,804		2,041,804			10
10a	Therapy			340,604	340,604		340,604		340,604			10a
11	Activities	138,828	45		138,873		138,873		138,873			11
12	Social Services	36,055			36,055		36,055		36,055			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* **rx consultant**			5,247	5,247		5,247		5,247			15
16	**TOTAL Health Care and Programs**	2,083,970	132,762	354,851	2,571,583		2,571,583		2,571,583			16
	C. General Administration											
17	Administrative	104,641			104,641		104,641		104,641			17
18	Directors Fees											18
19	Professional Services			(556,040)	(556,040)		(556,040)	10,312	(545,728)			19
20	Dues, Fees, Subscriptions & Promotions			5,703	5,703		5,703	220	5,923			20
21	Clerical & General Office Expenses	193,034	10,406	176,977	380,417		380,417	57,484	437,901			21
22	Employee Benefits & Payroll Taxes			452,967	452,967		452,967	19,499	472,466			22
23	Inservice Training & Education							49	49			23
24	Travel and Seminar			2,988	2,988		2,988	1,193	4,181			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			645,272	645,272		645,272	373,856	1,019,128			26
27	Other (specify):*											27
28	**TOTAL General Administration**	297,675	10,406	727,867	1,035,948		1,035,948	462,613	1,498,561			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,904,651	414,073	1,193,078	4,511,802		4,511,802	467,570	4,979,372			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Berkeley Nrsg Rehab Center #0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,753	33,753		33,753	23,118	56,871			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,879	17,879		17,879	55,637	73,516			32
33	Real Estate Taxes			209,680	209,680		209,680	47,856	257,536			33
34	Rent-Facility & Grounds			307,525	307,525		307,525	(301,999)	5,526			34
35	Rent-Equipment & Vehicles							1,146	1,146			35
36	Other (specify):*							(84)	(84)			36
37	**TOTAL Ownership**			568,837	568,837		568,837	(174,326)	394,511			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33,235		33,235		33,235		33,235			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			279,112	279,112		279,112		279,112			42
43	Other (specify):*			74,381	74,381		74,381	(74,381)				43
44	**TOTAL Special Cost Centers**		33,235	353,493	386,728		386,728	(74,381)	312,347			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,904,651	447,308	2,115,408	5,467,367		5,467,367	218,863	5,686,230			45

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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	(3,804)	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	26	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,381)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(84)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,243)		$	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)	297,106		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 297,106		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 218,863		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Berkeley Nrsg Rehab Center

ID# 0050534

Report Period Beginning: 1/1/25

Ending: 12/31/25

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	26	0	0	0	0	0	0	0	0	0	0	26	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	944	0	0	0	0	0	0	0	0	0	944	5
6	Maintenance	0	3,987	0	0	0	0	0	0	0	0	0	3,987	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	26	4,931	0	0	0	0	0	0	0	0	0	4,957	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	4,412	5,900	0	0	0	0	0	0	0	0	10,312	19
20	Fees, Subscriptions & Promotions	0	0	220	0	0	0	0	0	0	0	0	220	20
21	Clerical & General Office Expenses	0	56,687	797	0	0	0	0	0	0	0	0	57,484	21
22	Employee Benefits & Payroll Taxes	0	19,499	0	0	0	0	0	0	0	0	0	19,499	22
23	Inservice Training & Education	0	49	0	0	0	0	0	0	0	0	0	49	23
24	Travel and Seminar	0	1,193	0	0	0	0	0	0	0	0	0	1,193	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	0	373,856	0	0	0	0	0	0	0	0	373,856	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	81,840	380,773	0	0	0	0	0	0	0	0	462,613	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	26	86,771	380,773	0	0	0	0	0	0	0	0	467,570	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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	(3,804)	0	26,922	0	0	0	0	0	0	0	0	23,118	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	55,637	0	0	0	0	0	0	0	0	0	55,637	32
33	Real Estate Taxes	0	47,856	0	0	0	0	0	0	0	0	0	47,856	33
34	Rent-Facility & Grounds	0	(301,999)	0	0	0	0	0	0	0	0	0	(301,999)	34
35	Rent-Equipment & Vehicles	0	1,146	0	0	0	0	0	0	0	0	0	1,146	35
36	Other (specify):*	(84)	0	0	0	0	0	0	0	0	0	0	(84)	36
37	TOTAL Ownership	(3,888)	(197,360)	26,922	0	0	0	0	0	0	0	0	(174,326)	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):*	(74,381)	0	0	0	0	0	0	0	0	0	0	(74,381)	43
44	TOTAL Special Cost Centers	(74,381)	0	0	0	0	0	0	0	0	0	0	(74,381)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(78,243)	(110,589)	407,695	0	0	0	0	0	0	0	0	218,863	45

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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	Highland Park	Consulting
Nancy Blisko	1			Woodbine Realty	Oak Park	Propco
				Integrity HCC Service	Skokie	Bookkeeping

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Integrity HCC Services LLC		$ 944	$ 944	1
2	V	6	Maintenance		Integrity HCC Services LLC		3,987	3,987	2
3	V	21	Office		Integrity HCC Services LLC		56,687	56,687	3
4	V	22	Benefits		Integrity HCC Services LLC		19,499	19,499	4
5	V	24	Travel Expense		Integrity HCC Services LLC		1,193	1,193	5
6	V	23	Seminars		Integrity HCC Services LLC		49	49	6
7	V	34	Rent		Integrity HCC Services LLC		5,526	5,526	7
8	V	35	Equipment Lease		Integrity HCC Services LLC		1,146	1,146	8
9	V	19	Professional Fees		Integrity HCC Services LLC		4,412	4,412	9
10	V	32	Interest Expense		Woodbine Realty		55,637	55,637	10
11	V	33	property tax expense	209,680	Woodbine Realty		257,536	47,856	11
12	V	31	amortization expense		Woodbine Realty				12
13	V	34	Rent	307,525	Woodbine Realty			(307,525)	13
14	Total			$ 517,205			$ 406,616	$ * (110,589)	14

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation expense	$	Woodbine Realty		$ 26,922	$ 26,922	15
16	V	21	Bank charges		Woodbine Realty		720	720	16
17	V	19	Audit costs		Woodbine Realty		5,900	5,900	17
18	V	21	Annual report		Woodbine Realty		77	77	18
19	V	26	Insurance		Integrity HCC Services LLC		432	432	19
20	V	26	Insurance	249,982	Woodbine Realty		623,406	373,424	20
21	V	20	dues and subs		Integrity HCC Services LLC		220	220	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 249,982			$ 657,677	$ * 407,695	39

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

STATE OF ILLINOIS **Ownership Listing-1**

Berkeley Nrsg Rehab Center

ID# **0050534**

Report Period Beginning: **1/1/25**

Ending: **12/31/25**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	JOSEPH		BLISKO	HIGHLAND PAI	IL	99.00000	99.00000	99.00000	1
2	NANCY		BLISKO	HIGHLAND PAI	IL	1.00000	1.00000	1.00000	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
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64									64
65									65
66									66
67									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

Berkeley Nrsg Rehab Center

ID# **0050534**

Report Period Beginning: **1/1/25**

Ending: **12/31/25**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
88									88
89									89
90									90
91									91
92									92
93									93
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138									138
139									139
140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

VII. RELATED PARTIES

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

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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13										13
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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	HUD		X	Mortgage	VARIOUS	8/24/12	$ 3,614,600	$ 2,286,702	9/1/40	2.8500	$ 55,637	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Wintrust Bank		X	Operations	Various			as needed		Various	17,879	6
7												7
8												8
9	TOTAL Facility Related						$ 3,614,600	$ 2,286,702			$ 73,516	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,614,600	$ 2,286,702			$ 73,516	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 11,099 Line # 26

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

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$	257,536	2
3. Under or (over) accrual (line 2 minus line 1).	$	257,536	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		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.	$	257,536	7

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020	182,525	9
	2021	187,098	10
	2022	191,999	11
	2023	190,433	12
	2024	257,536	13

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Berkeley Nrsg Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050534

CONTACT PERSON REGARDING THIS REPORT Dan Gaafar

TELEPHONE 317-237-5500 FAX #: -317-237-5503

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-29-03-983-A	Nursing Facility	$ 257,535.96	$ 257,535.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 257,535.96	$ 257,535.96

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Facility Name & ID Numb Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? YES

H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? NO

J. 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.

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		2009		$ 1,050,000	$ 26,922	39	$ 26,922	$	$ 436,814	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New Roofing System			40079	53,000	1,359	39	1,359		20,806	9
10	Cabinets/Carpet Removal & Plumbing Work			40102	1,872	48	39	48		719	10
11	New Acrylic Signs			40077	1,500	38	39	38		573	11
12	Cabling for Beds & Dining Room			40252	2,000	51	39	51		760	12
13	Bathroom Remodeling, Plumbing, and Materials			40255	2,588	66	39	66		983	13
14	Sprinkler System Repairs			40417	2,821	72	39	72		1,042	14
15	Sprinkler System Repairs			40458	4,579	117	39	117		1,672	15
16	Sprinkler System Repairs			40472	1,159	30	39	30		424	16
17	Sink and Drain Repairs			40185	6,475	166	39	166		2,371	17
18	Replacement Chiller Coil for Air Handler Unit			40351	4,125	106	39	106		1,543	18
19	Chiller Coil Installation			40352	1,583	41	39	41		593	19
20	Replacement Dryer Exhaust			40372	1,000	26	39	26		373	20
21	Replacement Fire Damper Motor			40409	1,556	40	39	40		576	21
22	Heating Systems Repair			40483	2,617	67	39	67		950	22
23	Awning			40288	2,500	64	39	64		944	23
24	Sprinkler System Repairs			40740	1,800	46	39	46		621	24
25	Plumbing Work			40654	3,250	83	39	83		1,115	25
26	New Flooring			40743	1,440	37	39	37		498	26
27	High resolution outdoor cameras			41204	19,028		39	488	488	19,516	27
28	Relocate nurses call system			41252	3,414		39	88	88	3,502	28
29	Provide door hardware			41003	3,800	97	39	97		1,174	29
30	Remove and repair Handrails			41003	11,455	294	39	294		3,539	30
31	Renovation of bathroom			41082	20,000	513	39	513		6,183	31
32	Integra Development			41130	309,000	7,923	39	7,923		95,525	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	* Install window, handrails, stone on walls in kitchen opening,	41540	$ 116,825	$ 2,996	39	$ 2,996	$	$ 33,829	37
38	door casings, wiring for time clock and lighting, exhaust fan								38
39	and doors in computer room, cove base, therapy room walls,								39
40	painting, chair rail, title, workstations, sink, fixtures, office								40
41	walls and painting, cove base, bathroom painting and tile,								41
42	sinks and toilet in nurses station, office, and bathroom								42
43									43
44	Main Hallway - celing tiles, handrail, carpet, cove base, paint								44
45	door casing, vinyl sheets, laminate walls, floor prep, signage,								45
46	lighting, elecrical wiring, molding								46
47	Hospice Hallway - cabinets, countertops, carpet, cove base,								47
48	vent covers, door casings, paint, vinyl sheets, laminate walls,								48
49	corner guards, floor reducers, signage, arwork w/ security								49
50	hardware, electrical wiring for lights and signs	41669	155,500	3,987	39	3,987		43,690	50
51									51
52	Remove existing window and create door opening, patch brick								52
53	prep foundation slab, install new door	41703	4,300	110	39	110		1,206	53
54									54
55	Flooring in resident rooms, cove base, wall coverings, painting,								55
56	electrical, new closet dividers, ceiling tiles, plumbing in bathrooms								56
57	Tile and grout in bathrooms	42139	44,407	1,139	39	1,139		10,773	57
58									58
59	Replace 10' of cast iron plumbing pipe	2016	1,950	50	39	50		423	59
60	Wall coverings, light fix, tile, electrical work in resident rooms	2016	24,697	633	39	633		5,356	60
61	New pit ladder installation	2016	2,801	72	39	72		608	61
62	Replace mixing valve	2016	3,272	84	39	84		710	62
63	Laundry fan replacement	2016	2,350	60	39	60		509	63
64	New water heater	2016	4,413	113	39	113		956	64
65	New roof fan	2016	5,200	133	39	133		1,127	65
66	New A/C blower motor	2016	1,292	33	39	33		279	66
67	New fan vent	2016	950	24	39	24		205	67
68	New fire panel board	2016	2,475	63	39	63		535	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,882,994	$ 47,706		$ 48,281	$ 575	$ 703,024	70

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,882,994	$ 47,706		$ 48,281	$ 575	$ 703,024	1
2	Replace existing outdoor carpet, debris container and	2016	108,800	2,790	39	2,790		23,596	2
3	removal, removal of existing floor and wall tiles in 11								3
4	resident rooms								4
5									5
6	New floor and wall tile and plumbing work in shower room	2017	17,985	461	39	461		3,459	6
7	New compressor	2017	10,500	269	39	269		2,019	7
8	New sidewalk	2017	8,100	208	39	208		1,559	8
9	Cooling tower and building circulation pump	2017	6,300	162	39	162		1,214	9
10					39				10
11	New Elevator Door	2017	3,800	97	39	97		729	11
12	Electrical work in patient care areas	2017	28,450	729	39	729		5,470	12
13									13
14	Install new security cameras	2018	1,328	34	39	34		221	14
15	Install new exhaust fan in heating unit	2018	2,770	71	39	71		463	15
16	Replace electrical box	2018	1,150	29	39	29		190	16
17									17
18	Walls	2019	2,700	69	39	69		380	18
19	Cooling Tower	2019	16,500	423	39	423		2,327	19
20	Valve Replacement	2019	6,100	156	39	156		859	20
21	Fire Sprinkler System Repair	2019	7,905	203	39	203		1,116	21
22	New Heater Installed	2019	3,850	99	39	99		544	22
23	Elevator Contract Work	2019	2,896	74	39	74		408	23
24	Installation of Metal Door	2019	2,800	72	39	72		395	24
25									25
26	install new phase 60 amp pan	2021	9,980	255	39	255		1,012	26
27	kitchen drain	2021	3,265	84	39	84		332	27
28	replace water line	2021	26,500	679	39	679		2,690	28
29	A/C Chiller	2021	44,320	1,136	39	1,136		4,498	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,198,993	$ 55,807		$ 56,383	$ 575	$ 756,506	34

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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	$	$	$	$		$	71
72	Current Year Purchases	4,866	4,866	487	(4,379)	5	4,866	72
73	Fully Depreciated Assets	1,198,114					1,198,114	73
74								74
75	TOTALS	$ 1,202,980	$ 4,866	$ 487	$ (4,379)		$ 1,202,980	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)	$ 3,401,973	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 60,673	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 56,870	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,804)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,959,486	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Woodbine Realty

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. [X] 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:				$ 307,525	28		3
4	Additions							4
5								5
6								6
7	TOTAL				$ 307,525 **			7

10. Effective dates of current rental agreement:
Beginning 8/24/12
Ending 9/30/40

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

	Fiscal Year Ending	Annual Rent
12.	/2026	$ 582,006
13.	/2027	$ 582,006
14.	/2028	$ 599,466

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

9. Option to Buy: [ ] YES [X] NO Terms: *

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

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

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	$		$ 140,992	$		$ 140,992	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			41,707			41,707	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			157,905			157,905	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				27,193		27,193	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): xray	39-2					1,960		1,960	12
13	Other (specify): labs	39-2					4,082		4,082	13
14	TOTAL			$		$ 340,604	$ 33,235		$ 373,839	14

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

STATE OF ILLINOIS

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/25 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 68,362	$ 68,362	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,764,670	1,764,670	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			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)**	$ 1,833,032	$ 1,833,032	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,134,110		15
16	Equipment, at Historical Cost	242,865		16
17	Accumulated Depreciation (book methods)	(575,013)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 801,962	$ 801,962	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,634,994	$ 2,634,994	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,621,949	$ 4,621,949	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	350,000	350,000	29
30	Accrued Salaries Payable	256,796	256,796	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,750	11,750	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,240,495	$ 5,240,495	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,240,495	$ 5,240,495	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,605,501)	$ (2,605,501)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,634,994	$ 2,634,994	48

*(See instructions.)

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,123,324)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,123,324)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	517,823	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 517,823	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)**	$ (2,605,501)	24 *

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,797,484	1
2	Discounts and Allowances for all Levels	(389,255)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,408,229	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	531,432	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 531,432	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	36,929	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 36,929	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,188	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,188	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	1,412	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,412	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,985,190	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	904,271	31
32	Health Care	2,571,583	32
33	General Administration	1,035,948	33
	B. Capital Expense		
34	Ownership	568,837	34
	C. Ancillary Expense		
35	Special Cost Centers	33,235	35
36	Provider Participation Fee	279,112	36
	D. Other Expenses (specify):		
37		74,381	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,467,367	40
41	**Income before Income Taxes (line 30 minus line 40)****	517,823	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 517,823	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 4,267,912.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	239,060.00	48
49	Medicare Part A	867,610.00	49
50	Other-(specify)	422,902.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,797,484	56

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,926	2,062	$ 113,223	$ 54.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,296	10,895	455,483	41.81	3
4	Licensed Practical Nurses	9,308	9,907	376,226	37.98	4
5	CNAs & Orderlies	32,919	35,275	884,342	25.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,924	2,070	43,470	21.00	9
10	Activity Assistants	3,490	3,976	91,694	23.06	10
11	Social Service Workers	1,425	1,433	34,445	24.04	11
12	Dietician					12
13	Food Service Supervisor	1,800	1,893	49,997	26.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,123	12,057	258,742	21.46	15
16	Dishwashers					16
17	Maintenance Workers	2,005	2,063	49,490	23.99	17
18	Housekeepers	3,093	3,706	77,361	20.87	18
19	Laundry	2,996	3,442	74,144	21.54	19
20	Administrator	1,985	2,036	97,883	48.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,894	2,015	53,292	26.45	23
24	Clerical	7,781	8,237	212,380	25.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,657	1,709	32,479	19.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	95,622	102,776	$ 2,904,651 *	$ 28.26	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 213	1-2	35
36	Medical Director	Monthly	9,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,247	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,460		49

C. CONTRACT NURSES

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

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Philip Morgenstern	administrator	0	$ 104,641
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,641

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Integrity HCC Services LLC	Bookeeping	$ 108,000
Bradley and Associates	Accounting	5,158
Skidelsky and Assoc	legal	15,000
Tax Opportunity of America	Accounting	690
JB Healthcare	Mgmt Services	(684,888)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ (556,040)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,411
Unemployment Compensation Insurance	48,355
FICA Taxes	225,686
Employee Health Insurance	48,212
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefis	69,802
TOTAL (agree to Schedule V, line 22, col.8)	$ 472,466

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,430
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	
Other Fees	3,443
Other Dues	1,050
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,923

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,988
Other Travel	1,193
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,181

**See instructions.

Facility Name & ID Number Berkeley Nrsg Rehab Center # 0050534 Report Period Beginning: 1/1/25 Ending: 12/31/25

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
Total	

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

Total	

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

Total	

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ **18,619** Line **10**

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **279,112**
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **NO**

(10) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

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

(12) 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? **YES**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**

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**

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

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

(15) 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. **NO**
Attach invoices and a summary of services for all architect and appraisal fees.