

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0049247 Facility Name: Berkshire Nursing And Rehab Center Address: 8200 West Roosevelt Road Forest Park 60130 County: Cook Telephone Number: (708) 488-9850 Fax #: (708) 488-9870 HFS ID Number: 363402398001 Date of Initial License for Current Owners: 07/01/07 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steve Lavenda Telephone Number: (847) 236-1111 Email Address: slavenda@frrcpas.com	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) Cary C. Buxbaum, C.P.A. (Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015 (Telephone) (847) 236-1111 Fax #: (847) 236-1155 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 Berkshire Nursing And Rehab Center

0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>232</u>	Skilled (SNF)	<u>232</u>	<u>84,912</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>232</u>	TOTALS	<u>232</u>	<u>84,912</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>44,622</u>	<u>752</u>	<u>10,509</u>	<u>55,883</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>44,622</u>	<u>752</u>	<u>10,509</u>	<u>55,883</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.81%

D. How many bed-hold days during this year were paid by the Department? N/A (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)
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 ☐

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 7/1/2007

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/1/2007 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 232 and days of care provided 8,326

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

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12
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	204,205	20,436	36,025	260,666		260,666	15,891	276,557			1
2	Food Purchase		245,643		245,643		245,643	(33)	245,610			2
3	Housekeeping	203,994	27,030		231,024		231,024		231,024			3
4	Laundry	82,616	21,400		104,016		104,016		104,016			4
5	Heat and Other Utilities			311,620	311,620		311,620	(11,603)	300,017			5
6	Maintenance	58,214	54,267	178,263	290,744		290,744	(13,253)	277,492			6
7	Other (specify):*							2,936	2,936			7
8	TOTAL General Services	549,029	368,776	525,908	1,443,713		1,443,713	(6,062)	1,437,651			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	2,849,016	273,315	96,908	3,219,239		3,219,239	(45,361)	3,173,878			10
10a	Therapy	79,367	29,828		109,195		109,195		109,195			10a
11	Activities	128,748	12,376	2,288	143,412		143,412		143,412			11
12	Social Services	71,087		3,150	74,237		74,237		74,237			12
13	CNA Training											13
14	Program Transportation			30,213	30,213		30,213	3,313	33,526			14
15	Other (specify):*							10,024	10,024			15
16	TOTAL Health Care and Programs	3,128,218	315,519	149,059	3,592,796		3,592,796	(32,024)	3,560,772			16
	C. General Administration											
17	Administrative	148,761		92,899	241,660		241,660	50,997	292,657			17
18	Directors Fees											18
19	Professional Services			571,969	571,969	(127,686)	444,283	(297,935)	146,348			19
20	Dues, Fees, Subscriptions & Promotions			45,888	45,888		45,888	(19,645)	26,243			20
21	Clerical & General Office Expenses	140,505		370,954	511,459		511,459	(186,000)	325,459			21
22	Employee Benefits & Payroll Taxes			764,105	764,105		764,105		764,105			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,036	2,036		2,036	2,588	4,624			24
25	Other Admin. Staff Transportation			6,372	6,372		6,372	2,841	9,213			25
26	Insurance-Prop.Liab.Malpractice			323,263	323,263		323,263	2,847	326,110			26
27	Other (specify):*							39,453	39,453			27
28	TOTAL General Administration	289,266		2,177,486	2,466,752	(127,686)	2,339,066	(404,854)	1,934,212			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,966,513	684,295	2,852,453	7,503,261	(127,686)	7,375,575	(442,940)	6,932,635			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			112,403	112,403		112,403	(24,921)	87,482			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,385	50,385		50,385	5,960	56,345			32
33	Real Estate Taxes			399,685	399,685	127,686	527,371	7,045	534,416			33
34	Rent-Facility & Grounds			1,095,288	1,095,288		1,095,288	(12,000)	1,083,288			34
35	Rent-Equipment & Vehicles			35,303	35,303		35,303	8,000	43,303			35
36	Other (specify):*											36
37	TOTAL Ownership			1,693,064	1,693,064	127,686	1,820,750	(15,916)	1,804,834			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		378,253	871,450	1,249,703		1,249,703	(32,567)	1,217,136			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			623,196	623,196		623,196		623,196			42
43	Other (specify):*	39,708		474,307	514,015		514,015	(514,015)				43
44	TOTAL Special Cost Centers	39,708	378,253	1,968,953	2,386,914		2,386,914	(546,582)	1,840,332			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,006,221	1,062,548	6,514,470	11,583,239		11,583,239	(1,005,438)	10,577,801			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	(13,241)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(33,603)	30		9
10	Interest and Other Investment Income	(3,334)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	02		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	(3,107)	21		18
19	Entertainment	(7,053)	21		19
20	Contributions	(21,274)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(278,390)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(624,116)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (984,151)		\$	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)	(21,287)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (21,287)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,005,438)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

ID#

0049247

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (23,862)	21	1
2	Marketing - Salaries	(39,708)	43	2
3	Theft & Damage Loss	(1,130)	21	3
4	Non-Allowable Fees	(462,995)	43	4
5	Marketing	(4,812)	43	5
6	Non-Allowable Legal	(6,321)	19	6
7	Additional R&M	19,750	06	7
8	Non- Allowable Equipment Rental	(222)	35	8
9	Prior Period Legal Fees	(1,757)	19	9
10	Non Allowable Professional Fees	(86,710)	19	10
11	Capitalized R&M	(2,597)	06	11
12	Rental Income	(13,752)	06	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	(624,116)		49

ID#0049247

Report Period Beginning:01/01/12

Ending:12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
30	Depreciation	(33,603)		2,407		6,275							(24,921)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,334)		3,067		6,227							5,960	32
33	Real Estate Taxes					7,045							7,045	33
34	Rent-Facility & Grounds			13,322		(25,322)							(12,000)	34
35	Rent-Equipment & Vehicles	(222)		3,328	4,894								8,000	35
36	Other (specify):*													36
37	TOTAL Ownership	(37,159)		22,124	4,894	(5,775)							(15,916)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(32,567)						(32,567)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(507,515)			(6,500)								(514,015)	43
44	TOTAL Special Cost Centers	(507,515)			(6,500)		(32,567)						(546,582)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(984,151)		49,300	(32,583)	(5,437)	(32,567)						(1,005,438)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name See 6-Supplemental	Ownership %	Name See 6-Supplemental	City	Name See 6-Supplemental	City	Type of Business

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

X 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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	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	5	UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 1,638	\$ 1,638	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	3,151	3,151	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	240	240	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	44,027	44,027	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	2,710	2,710	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	1,401	1,401	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	114,954	114,954	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	574	574	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,918	1,918	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	2,847	2,847	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	30,431	30,431	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	2,407	2,407	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	3,067	3,067	27
28	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	25,322	25,322	28
29	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	2,888	2,888	29
30	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	440	440	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	19	BOOKKEEPING FEES	140,720	YAM MANAGEMENT, LLC	100.00%		(140,720)	35
36	V	19	ACCOUNTING	35,995	YAM MANAGEMENT, LLC	100.00%		(35,995)	36
37	V	34	RENT	12,000	YAM MANAGEMENT, LLC	100.00%		(12,000)	37
38	V								38
39	Total			\$ 188,715			\$ 238,015	\$ * 49,300	39

* 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	1	DIETARY	\$	YAM CONSULTING, LLC	100.00%	\$ 15,891	\$ 15,891	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	2,696	2,696	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	75,719	75,719	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	3,313	3,313	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	10,024	10,024	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	40,870	40,870	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	683	683	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	150	150	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	12,588	12,588	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	2,014	2,014	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	923	923	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	9,022	9,022	26
27	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	4,894	4,894	27
28	V	6	REPAIRS AND MAINTENANCE SALARY		YAM CONSULTING, LLC	100.00%	3,715	3,715	28
29	V								29
30	V								30
31	V								31
32	V	6	PAINTER	23,520	YAM CONSULTING, LLC	100.00%		(23,520)	32
33	V	10	DIETICIAN CONSULTING	34,980	YAM CONSULTING, LLC	100.00%		(34,980)	33
34	V	10	NURSE CONSULTING	86,100	YAM CONSULTING, LLC	100.00%		(86,100)	34
35	V	17	DIR. OF OPERATIONS CONSULT	33,900	YAM CONSULTING, LLC	100.00%		(33,900)	35
36	V	19	DATA PROCESSING FEES	30,085	YAM CONSULTING, LLC	100.00%		(30,085)	36
37	V	43	MARKETING	6,500	YAM CONSULTING, LLC	100.00%		(6,500)	37
38	V								38
39	Total			\$ 215,085			\$ 182,502	\$ * (32,583)	39

* 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	19	PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 260	\$ 260	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		78	78	16
17	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		6,275	6,275	17
18	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		6,227	6,227	18
19	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		7,045	7,045	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	25,322	8131 N. MONTICELLO, LLC			(25,322)	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			\$ 25,322			\$ 19,885	\$ * (5,437)	39

* 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.

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		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	39	Therapy Services	\$ 814,166	Renewal Rehab	100.00%	\$ 781,599	\$ (32,567)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								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			\$ 814,166			\$ 781,599	\$ * (32,567)	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								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			\$			\$	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								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			\$			\$	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								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			\$			\$	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								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			\$			\$	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	1219 LIMITED PARTNERSHIP	0.830%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	257 LIMITED PARTNERSHIP	0.830%	DOLTON NURSING & REHAB,LLC	DOLTON	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	42170 LIMITED PARTNERSHIP	0.840%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	3
4	CHRISTINA INOFRE	1.000%	EXCEPTIONAL CARE, LLC	BURBANK	RENEWAL REHAB	SKOKIE	THERAPY COMPANY	4
5	DAVID BERKOWITZ	42.000%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				5
6	DAVID KLEINER	1.000%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				6
7	ISAAC SCHEINER UGMA RACHEL SCHEINER	1.000%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				7
8	JACOB SCHEINER UGMA ARI SCHEINER	0.500%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				8
9	JACOB SCHEINER UGMA DOV SCHEINER	0.500%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				9
10	JACOB SCHEINER UGMA NOSSON SCHEINER	0.500%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				10
11	JOSHUA WEINSTEIN	2.000%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				11
12	MARLEE ASSOCIATES, LLC	4.900%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				12
13	MORDECHAI GRONER	1.000%	ROCKFORD NUR. & REHAB	ROCKFORD				13
14	SARAH LEINER	1.000%	SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				14
15	YOSEF MEYSTEL	42.100%	THE ARBORS AT MICHIGAN CITY	MICHIGAN CITY , IN				15
16			THE COPPERAS HOLLOW	CALDWELL, TX				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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	Yosef Meystel	Owner	Administrative	42.10%	See Attached	4.9	12.25%	Mgmt. Fees	\$ 24,000	17-03	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	2.4	6.00%	Alloc. Salary	7,415	17-07	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	2.4	12.00%	Alloc. Salary	2,788	17-07	3
4	David Berkowitz	Owner	Administrative	42.00%	See Attached	4.9	12.25%	Mgmt. Fees	35,000	17-03	4
5	Cynthia Meystel	Relative	Administrative	0.00%	See Attached	0.4	12.12%	Alloc. Salary	558	21-07	5
6	Christina Inofre	Owner	Nursing	1.00%	See Attached	4.9	12.25%	Alloc. Salary	12,651	10-07	6
7											7
8	Where Applicable, The Amounts Reported On This Page Have Been Adjusted From The Actual Costs To Reflect Only Amounts Anticipated To Be Considered Allowable										8
9	By The IL. Department of HFS										9
10											10
11											11
12											12
13								TOTAL	\$ 82,412		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 YAM MANAGEMENT, LLC
Street Address 8131 N. MONTICELLO
City / State / Zip Code SKOKIE, ILLINOIS 60076
Phone Number (847) 673-6767
Fax Number (847) 673-6768

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. BED DAYS	697,482	17	\$ 13,451	\$	84,912	\$ 1,638	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	697,482	17	25,882	8,567	84,912	3,151	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	697,482	17	1,974		84,912	240	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	697,482	17	361,644	361,644	84,912	44,027	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	22,257		84,912	2,710	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	11,509		84,912	1,401	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	697,482	17	944,249	887,220	84,912	114,954	7
8	24	SEMINARS	AVAIL. BED DAYS	697,482	17	4,715		84,912	574	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	15,759		84,912	1,918	9
10	26	INSURANCE	AVAIL. BED DAYS	697,482	17	23,390		84,912	2,847	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	249,963		84,912	30,431	11
12	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	19,767		84,912	2,407	12
13	32	INTEREST	AVAIL. BED DAYS	697,482	17	25,195		84,912	3,067	13
14	34	RENT	AVAIL. BED DAYS	697,482	17	208,000		84,912	25,322	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	23,725		84,912	2,888	15
16	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	697,482	17	3,615		84,912	440	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,955,095	\$ 1,257,431		\$ 238,015	25

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 YAM CONSULTING, LLC
Street Address 8131 N. MONTICELLO
City / State / Zip Code SKOKIE, ILLINOIS 60076
Phone Number (847) 673-6767
Fax Number (847) 673-6768

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY	AVAIL. BED DAYS	697,482	17	\$ 130,530	\$ 122,357	84,912	\$ 15,891	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	697,482	17	22,148		84,912	2,696	2
3	10	NURSING SALARY	AVAIL. BED DAYS	697,482	17	621,969	621,969	84,912	75,719	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	697,482	17	27,214		84,912	3,313	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	697,482	17	82,340		84,912	10,024	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	697,482	17	335,714	335,714	84,912	40,870	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	5,608		84,912	683	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	1,231		84,912	150	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	697,482	17	103,402	93,384	84,912	12,588	9
10	24	SEMINARS	AVAIL. BED DAYS	697,482	17	16,540		84,912	2,014	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	7,585		84,912	923	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	74,111		84,912	9,022	12
13	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	40,201		84,912	4,894	13
14	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	697,482	17	30,518		84,912	3,715	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,499,111	\$ 1,173,424		\$ 182,502	25

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 8131 N. MONTICELLO, LLC
Street Address 8131 N. MONTICELLO
City / State / Zip Code SKOKIE, ILLINOIS 60076
Phone Number (847) 673-6767
Fax Number (847) 673-6768

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	\$ 2,136	\$	84,912	\$ 260	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	645		84,912	78	2
3	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	51,541		84,912	6,275	3
4	32	INTEREST EXPENSE	AVAIL. BED DAYS	697,482	17	51,147		84,912	6,227	4
5	33	REAL ESTATE TAXES	AVAIL. BED DAYS	697,482	17	57,872		84,912	7,045	5
6								84,912		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					\$ 163,341	\$		\$ 19,885	25

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Renewal Rehab
Street Address 8131 N. MONTICELLO
City / State / Zip Code SKOKIE, ILLINOIS 60076
Phone Number (847) 673-6767
Fax Number (847) 673-6768

	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	39	Therapy Services	Direct		5	\$	\$		\$ 781,599	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					\$	\$		\$ 781,599	25

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

()

()

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/12 Ending: 12/31/12

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							\$					\$	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Private Bank		X	Line of Credit				1,049,172				45,721	6
7				Insurance Policy								4,664	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	1,049,172				\$ 50,385	9
	B. Non-Facility Related*												
10	Interest Income		X									(3,334)	10
11	Allocated from YAM Management											3,067	11
12	Allocated from 8131 N. Monticello											6,227	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$					\$ 5,960	14
15	TOTALS (line 9+line14)						\$	1,049,172				\$ 56,345	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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							\$				\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$				\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15							\$				\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	305,800	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.)				\$	359,787	2
3. Under or (over) accrual (line 2 minus line 1).				\$	53,987	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	352,742	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.)				\$	127,686	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 \$ 238,733 For 2009 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.				\$	534,415	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007	334,567	8			
	2008	350,230	9			
	2009	531,054	10			
	2010	289,122	11			
	2011	352,742	12			
2012 R/E Tax Accrual = 2011 R/E Tax Allocated from 8131 N. Monticello- \$7,045						
Beginning Accrual Adjusted						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Berkshire Nursing And Rehab Center</u>	COUNTY	<u>Cook</u>
---------------	---	--------	-------------

FACILITY IDPH LICENSE NUMBER 0049247

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>15-24-100-020-0000</u>	<u>Long Term Care Property</u>	\$ <u>352,742.32</u>	\$ <u>352,742.32</u>
2.	<u>10-23-325-045-0000</u>	<u>Management Company</u>	\$ <u>66,065.10</u>	\$ <u>7,045.40</u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>418,807.42</u>	\$ <u>359,787.72</u>

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? X YES NO

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Berkshire Nursing And Rehab Center</u>	COUNTY	<u>Cook</u>
---------------	---	--------	-------------

FACILITY IDPH LICENSE NUMBER 0049247

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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?

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,467

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from 8131 N. Monticello</u>			<u>\$ 10,835</u>	1
2					2
3	TOTALS			<u>\$ 10,835</u>	3

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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		2007		15,031		20	833	833	4,458
10	Various		2008		91,691		20	8,750	8,750	39,230
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

*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	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	128,267	7,615		4,527	(3,088)	11,085	68
69	Financial Statement Depreciation		112,403			(112,403)		69
70	TOTAL (lines 4 thru 69)	\$ 234,989	\$ 120,018		\$ 14,110	\$ (105,908)	\$ 54,773	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Berkshire Nursing And Rehab Center

0049247

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 234,989	\$ 120,018		\$ 14,110	\$ (105,908)	\$ 54,773	1
2	Wallcoverings/Kitchenettes	2009	48,939		20	4,894	4,894	15,905	2
3	Valve Replacement	2009	5,226		20	261	261	936	3
4	Parking Lot Seal Coat	2009	6,360		20	318	318	1,087	4
5	Removal Of Existing Carpet; Installation Of Tile	2010	15,450		20	3,090	3,090	9,270	5
6	Windows, Bumper Guards, Flooring	2010	32,533		20	2,170	2,170	5,423	6
7	Circulating Pump	2010	3,149		20	630	630	1,785	7
8	Windows, Bumper Guards, Flooring - Deposit	2010	21,573		20	1,439	1,439	3,596	8
9	3Rd Floor-Kitchenette, Flooring, Window Treatments	2010	31,567		20	2,106	2,106	5,262	9
10	Bumper/Corner Guards, Glooring, Windows, Chandelier	2010	143,470		20	9,569	9,569	23,916	10
11	Water Heater	2011	34,880		20	2,907	2,907	5,571	11
12	New Condensor & Motor	2011	10,608		20	1,061	1,061	1,503	12
13	Security System - Cameras	2011	3,107		20	155	155	207	13
14	2Nd Floor Resident Rooms - Flooring	2011	36,239		20	1,812	1,812	3,322	14
15	2Nd Floor Resident Rooms - Bumper Guards, Assist Rails, Headb	2011	24,555		20	1,228	1,228	2,251	15
16	2Nd Floor Resident Rooms - Painting	2011	18,056		20	903	903	1,655	16
17	2Nd Floor Resident Rooms - Cubicle Curtains, Lighting, Electrical	2011	24,838		20	1,242	1,242	2,277	17
18	Offices & Computer Room - Painting, Carpeting, Flooring	2011	14,943		20	747	747	872	18
19	Vestibule - Flooring, Wallcovering, Motion Doors	2011	31,591		20	1,580	1,580	1,843	19
20	Lobby - Wallcoverings, Lighting, Granite Counter & Tiles	2011	11,137		20	557	557	650	20
21	Atrium - Wallcoverings, Corner Guards	2011	5,655		20	283	283	330	21
22	Third Floor Corner Guards	2011	3,517		20	176	176	205	22
23	4Th Floor Resident Rooms - Cubicle Curtains, Window Treatmen	2011	21,452		20	1,073	1,073	1,251	23
24	Window Treatments	2012	2,793		20	326	326	326	24
25	Compressor Replacement	2012	27,437		20	686	686	686	25
26	Compressor Replacement	2012	24,438		20	407	407	407	26
27	Cleanup From Rtaa Burnout	2012	12,567		20	209	209	209	27
28	Rtaa Controll Panel	2012	5,430		20	91	91	91	28
29	Fire Pump	2012	3,495		20	44	44	44	29
30	Rebuild Boiler Pump	2012	2,597		20	130	130	130	30
31	Lined Panels And Cubicle Curtains	2012	44,827		20	2,241	2,241	2,241	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 907,417	\$ 120,018		\$ 56,443	\$ (63,575)	\$ 148,025	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 907,417	\$ 120,018		\$ 56,443	\$ (63,575)	\$ 148,025	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 907,417	\$ 120,018		\$ 56,443	\$ (63,575)	\$ 148,025	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 907,417	\$ 120,018		\$ 56,443	\$ (63,575)	\$ 148,025	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 907,417	\$ 120,018		\$ 56,443	\$ (63,575)	\$ 148,025	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 907,417	\$ 120,018		\$ 56,443	\$ (63,575)	\$ 148,025	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 907,417	\$ 120,018		\$ 56,443	\$ (63,575)	\$ 148,025	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	84,187	2,503	39	2,159	(344)	5,307	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from YAM Management	2010	4,011	103	20	401	298	911	9
10	Allocated from 8131 N. Monticello	2010	37,711	3,771	20	1,886	(1,885)	4,786	10
11	Allocated from YAM Management	2012	2,358	1,238	20	81	(1,157)	81	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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 128,267	\$ 7,615		\$ 4,527	\$ (3,088)	\$ 11,085	34

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	\$ 193,420	\$ 29	\$ 28,299	\$ 28,270	10	\$ 97,142	71
72	Current Year Purchases	18,258	991	1,663	672	10	1,663	72
73	Fully Depreciated Assets	28,137				10	28,137	73
74								74
75	TOTALS	\$ 239,815	\$ 1,020	\$ 29,962	\$ 28,942		\$ 126,942	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		Allocated from YAM Managemer	2011	\$ 4,140	\$ 45	\$ 1,075	\$ 1,030	5	\$ 1,198
77									
78									
79									
80	TOTALS			\$ 4,140	\$ 45	\$ 1,075	\$ 1,030		\$ 1,198

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)			\$ 1,162,207
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 121,083
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 87,480
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ (33,603)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 276,165

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: Forest Park Property, LLC
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:		232		\$ 1,083,288			3
4	Additions							4
5								5
6								6
7	TOTAL		232		\$ 1,083,288			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: 19,720,000 *

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: \$ 19,498
- Description: See Attached Schedule

(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	Facility	Infiniti/Lexus	\$ 1080.49/470	\$ 16,023	17
18	Allocated from YAM Consulting			4,894	18
19	Allocated from YAM Management			2,888	19
20					20
21	TOTAL		\$	23,805	21

10. Effective dates of current rental agreement:

Beginning 09/04/2007
Ending 12/31/2026

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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)	
		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)	\$			

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	39 - 03	hrs	\$		\$ 346,212	\$		\$ 346,212	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			126,027			126,027	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			366,583			366,583	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				369,567		369,567	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					32,628	8,686		41,314	13
14	TOTAL			\$		\$ 871,450	\$ 378,253		\$ 1,249,703	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 564,750	\$	1
2	Cash-Patient Deposits	42,892		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,410,694		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	227,876		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	714,918		8
9	Other(specify): See Attached Schedule	630,842		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,591,972	\$	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	829,470		15
16	Equipment, at Historical Cost	306,383		16
17	Accumulated Depreciation (book methods)	(314,539)		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): See Attached Schedule	515,487		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,336,801	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,928,773	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 690,680	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,432		28
29	Short-Term Notes Payable	1,049,172		29
30	Accrued Salaries Payable	297,924		30
31	Accrued Taxes Payable (excluding real estate taxes)	56,322		31
32	Accrued Real Estate Taxes(Sch.IX-B)	352,742		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	243,585		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,755,857	\$	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	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,755,857	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,172,916	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,928,773	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,687,315	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,687,319	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	958,747	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	(473,150)	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)	\$ 485,597	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)	\$ 3,172,916	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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,794,179	1
2	Discounts and Allowances for all Levels	(2,392,685)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,401,494	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,487,148	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,487,148	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	13,752	16
17	Sale of Drugs	344,136	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,817	19
20	Radiology and X-Ray	3,290	20
21	Other Medical Services	18,082	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 410,077	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,334	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,334	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	239,933	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 239,933	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,541,986	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,443,713	31
32	Health Care	3,592,796	32
33	General Administration	2,466,752	33
	B. Capital Expense		
34	Ownership	1,693,064	34
	C. Ancillary Expense		
35	Special Cost Centers	1,763,718	35
36	Provider Participation Fee	623,196	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,583,239	40
41	Income before Income Taxes (line 30 minus line 40)**	958,747	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 958,747	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,497,100	44
45	Private Pay - Net Inpatient Revenue	161,935	45
46	Medicare - Net Inpatient Revenue	1,416,910	46
47	Other-(specify) Insurance	325,549	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,401,494	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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	2,205	2,361	\$ 109,021	\$ 46.18	1
2	Assistant Director of Nursing	2,002	2,128	80,228	37.71	2
3	Registered Nurses	14,551	15,676	470,902	30.04	3
4	Licensed Practical Nurses	42,330	45,430	1,186,625	26.12	4
5	CNAs & Orderlies	87,748	94,627	987,908	10.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,050	7,602	79,367	10.44	8
9	Activity Director	1,984	2,095	30,043	14.34	9
10	Activity Assistants	9,714	10,368	98,705	9.52	10
11	Social Service Workers	4,287	4,468	71,087	15.91	11
12	Dietician					12
13	Food Service Supervisor	1,956	2,101	30,891	14.70	13
14	Head Cook	4,276	4,720	50,743	10.75	14
15	Cook Helpers/Assistants	11,043	12,344	122,571	9.93	15
16	Dishwashers					16
17	Maintenance Workers	3,047	3,169	58,214	18.37	17
18	Housekeepers	18,129	19,805	203,994	10.30	18
19	Laundry	7,587	8,491	82,616	9.73	19
20	Administrator	2,790	2,954	116,357	39.39	20
21	Assistant Administrator	1,312	1,390	32,404	23.31	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,848	7,674	140,505	18.31	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	448	489	13,453	27.51	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,224	2,417	40,587	16.79	33
34	TOTAL (lines 1 - 33)	231,530	250,309	\$ 4,006,221 *	\$ 16.01	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	655	\$ 36,025	01-03	35
36	Medical Director	Monthly	16,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,156	86,700	10-03	38
39	Pharmacist Consultant	Monthly	10,208	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	2,288	11-03	44
45	Social Service Consultant	53	3,150	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,902	\$ 154,871		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.

Facility Name & ID Number		Berkshire Nursing And Rehab Center		STATE OF ILLINOIS		Page 21		
		# 0049247		Report Period Beginning:		01/01/12 Ending: 12/31/12		
XIX. SUPPORT SCHEDULES								
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lisa Ulbert	Administrator	0.00%	\$ 116,357	Workers' Compensation Insurance	\$ 125,463	IDPH License Fee	\$	
Moshe Freedman	Asst admin	0.00%	32,404	Unemployment Compensation Insurance	130,470	Advertising: Employee Recruitment	850	
				FICA Taxes	289,500	Health Care Worker Background Check	5,382	
				Employee Health Insurance	168,140	(Indicate # of checks performed 344)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	15,976	
				Union Pension Fund	44,079	Licenses & Permits	2,406	
				Life Insurance	85	Allocated From YAM Mgmt	1,401	
				Employee Meals	653	Allocated from YAM Consulting	150	
				Other Employee Benefits	5,715	See Supplemental Schedule	78	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)			\$ 148,761	\$ 764,105		\$ 26,243		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Yosef Meystel			\$ 24,000			\$	Out-of-State Travel	\$
Management Fees - David Berkowitz			35,000					
YAM Administrative Consulting			33,900					
					</			

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	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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?

Yes

If YES, give association name and amount.

ICLTC \$20,968
- (3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

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

\$37,973

Line

10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9) Are you presently operating under a sublease agreement?

YES

X

NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$623,196

This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

N/A

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$N/A
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100% ln 14

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?

N/A

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.

\$
- (17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

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

SEE ACCOUNTANTS' COMPILATION REPORT