FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0049247

Facility Name: Berkshire Nursing And Rehab Center

Address: 8200 West Roosevelt Road (Number) Forest Park (City) 60130 (Zip Code)

County: Cook

Telephone Number: (708) 488-9850 **Fax #** (708) 488-9870

HFS ID Number:

Date of Initial License for Current Owners: 07/01/07

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(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: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	232	Skilled (SNF)	232	84,680	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	232	TOTALS	232	84,680	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	42,495	2,259	7,423	52,177	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,495	2,259	7,423	52,177	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.62%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X] Date 7/1/2007 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 232 and days of care provided 7,423

Medicare Intermediary National Govenmental Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	209,202	19,122	32,368	260,692		260,692	(16,009)	244,683			1
2	Food Purchase		214,078		214,078		214,078	(93)	213,985			2
3	Housekeeping	203,045			203,045		203,045		203,045			3
4	Laundry	73,959	24,399		98,358		98,358		98,358			4
5	Heat and Other Utilities			278,629	278,629		278,629	1,875	280,504			5
6	Maintenance	77,148	27,506	111,314	215,968		215,968	25,359	241,327			6
7	Other (specify):*							2,185	2,185			7
8	TOTAL General Services	563,354	285,105	422,311	1,270,770		1,270,770	13,317	1,284,087			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,522,709	237,532	117,281	2,877,522		2,877,522	(33,585)	2,843,937			10
10a	Therapy	58,218			58,218		58,218		58,218			10a
11	Activities	140,689	15,204	1,810	157,703		157,703		157,703			11
12	Social Services	58,603		3,245	61,848		61,848		61,848			12
13	CNA Training											13
14	Program Transportation			500	500		500	4,725	5,225			14
15	Other (specify):*							9,172	9,172			15
16	TOTAL Health Care and Programs	2,780,219	252,736	140,836	3,173,791		3,173,791	(19,688)	3,154,103			16
	C. General Administration											
17	Administrative	104,878		99,196	204,074		204,074	38,949	243,023			17
18	Directors Fees											18
19	Professional Services			389,964	389,964	(38,600)	351,364	(249,796)	101,568			19
20	Dues, Fees, Subscriptions & Promotions			63,315	63,315		63,315	(24,436)	38,879			20
21	Clerical & General Office Expenses	171,720	1,755	405,892	579,367		579,367	(254,781)	324,586			21
22	Employee Benefits & Payroll Taxes			703,443	703,443		703,443		703,443			22
23	Inservice Training & Education											23
24	Travel and Seminar			967	967		967	1,727	2,694			24
25	Other Admin. Staff Transportation			12,209	12,209		12,209	4,317	16,526			25
26	Insurance-Prop.Liab.Malpractice			285,422	285,422		285,422	2,607	288,029			26
27	Other (specify):*							32,848	32,848			27
28	TOTAL General Administration	276,598	1,755	1,960,408	2,238,761	(38,600)	2,200,161	(448,565)	1,751,596			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,620,171	539,596	2,523,555	6,683,322	(38,600)	6,644,722	(454,936)	6,189,786			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.

Facility Name & ID Number Berkshire Nursing And Rehab Center #0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			91,368	91,368		91,368	(5,945)	85,423			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,536	31,536		31,536	6,000	37,536			32
33	Real Estate Taxes			289,122	289,122	38,600	327,722	3,583	331,305			33
34	Rent-Facility & Grounds			614,000	614,000		614,000	(14,000)	600,000			34
35	Rent-Equipment & Vehicles			20,064	20,064		20,064	10,653	30,717			35
36	Other (specify):*			9,569	9,569		9,569	(9,569)				36
37	**TOTAL Ownership**			1,055,659	1,055,659	38,600	1,094,259	(9,278)	1,084,981			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		332,653	635,290	967,943		967,943		967,943			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,020	127,020		127,020		127,020			42
43	Other (specify):*	115,253		565,214	680,467		680,467	(680,467)				43
44	**TOTAL Special Cost Centers**	115,253	332,653	1,327,524	1,775,430		1,775,430	(680,467)	1,094,963			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,735,424	872,249	4,906,738	9,514,411		9,514,411	(1,144,681)	8,369,730			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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(15,080)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,431)	30		9
10	Interest and Other Investment Income	(918)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(93)	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	(3,746)	21		18
19	Entertainment	(10,240)	21		19
20	Contributions	(13,950)	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	(310,586)	21		24
25	Fund Raising, Advertising and Promotional	(5,777)	20		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	(728,515)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,103,336)		$	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)	(41,345)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (41,345)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,144,681)		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

STATE OF ILLINOIS

Berkshire Nursing And Rehab Center

ID# 0049247

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (22,728)	21	1
2	Marketing - Salaries	(115,253)	43	2
3	Theft & Damage Loss	(1,194)	21	3
4	COPE Dues	(5,700)	20	4
5	State Replacement Tax	(7,817)	21	5
6	Other Income	(21,605)	21	6
7	Non-Allowable Fees	(545,000)	43	7
8	Marketing	(6,211)	43	8
9	Non-Allowable Legal	(7,270)	19	9
10	Additional R&M	37,252	06	10
11	Non- Allowable Veteran	(1,720)	10	11
12	Jury duty income	(17)	21	12
13	Asset disposal	(9,569)	36	13
14				14
15	Non Allowable Professional Fees	(1,683)	19	15
16	Non Allowable Professional Fees	(20,000)	19	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**	(728,515)		49

Berkshire Nursing And Rehab Center

ID# 0049247

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Berkshire Nursing And Rehab Center **#** 0049247 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(16,009)								(16,009)	1
2	Food Purchase	(93)											(93)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,875									1,875	5
6	Maintenance	22,172		3,187									25,359	6
7	Other (specify):*			225	1,960								2,185	7
8	**TOTAL General Services**	22,079		5,287	(14,049)								13,317	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,720)			(31,865)								(33,585)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				4,725								4,725	14
15	Other (specify):*				9,172								9,172	15
16	**TOTAL Health Care and Programs**	(1,720)			(17,968)								(19,688)	16
	C. General Administration													
17	Administrative			43,982	(5,033)								38,949	17
18	Directors Fees													18
19	Professional Services	(28,953)		(191,888)	(29,592)	637							(249,796)	19
20	Fees, Subscriptions & Promotions	(25,427)		809	105	77							(24,436)	20
21	Clerical & General Office Expenses	(377,933)		109,817	13,212	123							(254,781)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,251	476								1,727	24
25	Other Admin. Staff Transportation			3,638	679								4,317	25
26	Insurance-Prop.Liab.Malpractice			2,607									2,607	26
27	Other (specify):*			29,111	3,737								32,848	27
28	**TOTAL General Administration**	(432,313)		(673)	(16,416)	837							(448,565)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(411,954)		4,614	(48,433)	837							(454,936)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Berkshire Nursing And Rehab Center** **#** **0049247** **Report Period Beginning:** **01/01/11** **Ending:** **12/31/11**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(14,431)		2,048	83	6,355							(5,945)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(918)		124		6,794							6,000	32
33	Real Estate Taxes			5,724		(2,141)							3,583	33
34	Rent-Facility & Grounds			5,233		(19,233)							(14,000)	34
35	Rent-Equipment & Vehicles			3,019	7,634								10,653	35
36	Other (specify):*	(9,569)											(9,569)	36
37	TOTAL Ownership	(24,918)		16,148	7,717	(8,225)							(9,278)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(666,464)			(14,003)								(680,467)	43
44	TOTAL Special Cost Centers	(666,464)			(14,003)								(680,467)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,103,336)		20,762	(54,719)	(7,388)							(1,144,681)	45

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

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

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	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.**

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	YAM MANAGEMENT, LLC	100.00%	$ 1,875	$ 1,875	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	3,187	3,187	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	225	225	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	43,982	43,982	18
19	V	17	ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%			19
20	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	3,284	3,284	20
21	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	809	809	21
22	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	109,817	109,817	22
23	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	1,251	1,251	23
24	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	3,638	3,638	24
25	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	2,607	2,607	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	29,111	29,111	26
27	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	2,048	2,048	27
28	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	124	124	28
29	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	5,724	5,724	29
30	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	19,233	19,233	30
31	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	2,230	2,230	31
32	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	789	789	32
33	V								33
34	V	19	BOOKKEEPING FEES	130,020				(130,020)	34
35	V	19	DATA PROCESSING	28,152	YAM MANAGEMENT, LLC	100.00%		(28,152)	35
36	V	19	OTHER PROFESSIONAL FEES	37,000	YAM MANAGEMENT, LLC	100.00%		(37,000)	36
37	V	34	RENT	14,000	YAM MANAGEMENT, LLC	100.00%		(14,000)	37
38	V								38
39	Total			$ 209,172			$ 229,934	$ * 20,762	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	YAM CONSULTING, LLC	100.00%	$ 16,359	$ 16,359	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	1,960	1,960	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	73,675	73,675	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	4,725	4,725	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	9,172	9,172	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	24,163	24,163	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	6,408	6,408	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	105	105	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	13,212	13,212	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	476	476	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	679	679	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	3,737	3,737	26
27	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	83	83	27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	7,634	7,634	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	1	DIETICIAN CONSULTING	32,368	YAM CONSULTING, LLC	100.00%		(32,368)	33
34	V	10	NURSE CONSULTING	105,540	YAM CONSULTING, LLC	100.00%		(105,540)	34
35	V	17	DIR. OF OPERATIONS CONSULT	29,196	YAM CONSULTING, LLC	100.00%		(29,196)	35
36	V	19	DATA PROCESSING FEES	36,000	YAM CONSULTING, LLC	100.00%		(36,000)	36
37	V	43	MARKETING	14,003	YAM CONSULTING, LLC	100.00%		(14,003)	37
38	V								38
39	Total			$ 217,107			$ 162,388	$ * (54,719)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	8131 N. MONTICELLO, LLC	100.00%	$ 637	$ 637	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		77	77	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		123	123	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		6,355	6,355	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		6,794	6,794	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		3,583	3,583	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	19,233	8131 N. MONTICELLO, LLC			(19,233)	26
27	V	33	REAL ESTATE TAXES	5,724	8131 N. MONTICELLO, LLC			(5,724)	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			$ 24,957			$ 17,569	$ * (7,388)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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, BUILDING C	3
4	CHRISTINA INOFRE	1.000%	EXCEPTIONAL CARE, LLC	BURBANK				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 SCHEMER UGMA RACHEL SHEINER	1.000%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				7
8	JACOB SCHEMER UGMA ARI SHEINER	0.500%	JACKSONVILLE CARE CENTER	JACKSONVILLE				8
9	JACOB SCHEMER UGMA DOV SHEINER	0.500%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				9
10	JACOB SCHEMER UGMA NOSSON SHEINER	0.500%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				10
11	JOSHUA WEINSTEIN	2.000%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				11
12	MARLEE ASSOCIATES, LLC	4.900%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				12
13	MORDECHAI GRONER	1.000%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				13
14	SARAH LEINER	1.000%	ROCKFORD NUR. & REHAB	ROCKFORD				14
15	YOSEF MEYSTEL	42.100%	SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				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: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Owner	Administrative	42.10%	See Attached	4.9	12.25%	Mgmt. Fees	$ 27,000	17-03	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	2.5	6.25%	Alloc. Salary	7,459	17-07	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	2.5	12.50%	Alloc. Salary	2,840	17-07	3
4	David Berkowitz	Owner	Administrative	42.00%	See Attached	4.9	12.25%	Mgmt. Fees	43,000	17-03	4
5	Josh Weinstein	Owner	Administrative	2.00%	See Attached	4.9	12.25%	Alloc. Salary	9,648	17-07	5
6	Christina Inofre	Owner	Nursing	1.00%	See Attached	4.9	12.25%	Alloc. Salary	13,135	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	$ 103,082		13

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

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 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	5	UTILITIES	AVAIL. BED DAYS	686,836	17	$ 15,204	$	84,680	$ 1,875	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	686,836	17	25,846	8,238	84,680	3,187	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	686,836	17	1,829		84,680	225	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	356,736	356,736	84,680	43,982	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	26,635		84,680	3,284	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	6,564		84,680	809	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	890,719	835,933	84,680	109,817	7
8	24	SEMINARS	AVAIL. BED DAYS	686,836	17	10,148		84,680	1,251	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	29,510		84,680	3,638	9
10	26	INSURANCE	AVAIL. BED DAYS	686,836	17	21,145		84,680	2,607	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	236,117		84,680	29,111	11
12	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	16,611		84,680	2,048	12
13	32	INTEREST	AVAIL. BED DAYS	686,836	17	1,006		84,680	124	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	686,836	17	46,424		84,680	5,724	14
15	34	RENT	AVAIL. BED DAYS	686,836	17	156,000		84,680	19,233	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	18,091		84,680	2,230	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	686,836	17	6,400		84,680	789	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,864,985	$ 1,200,907		$ 229,934	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAIL. BED DAYS	686,836	17	$ 132,684	$ 123,698	84,680	$ 16,359	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	686,836	17	15,896		84,680	1,960	2
3	10	NURSING SALARY	AVAIL. BED DAYS	686,836	17	597,577	597,577	84,680	73,675	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	686,836	17	38,325		84,680	4,725	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	686,836	17	74,394		84,680	9,172	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	195,987	195,987	84,680	24,163	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	51,975		84,680	6,408	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	849		84,680	105	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	107,160	91,547	84,680	13,212	9
10	24	SEMINARS	AVAIL. BED DAYS	686,836	17	3,858		84,680	476	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	5,508		84,680	679	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	30,309		84,680	3,737	12
13	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	673		84,680	83	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	61,921		84,680	7,634	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,317,116	$ 1,008,809		$ 162,388	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	$ 5,168	$	84,680	$ 637	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	624		84,680	77	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	686,836	17	1,000		84,680	123	3
4	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	51,542		84,680	6,355	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	686,836	17	55,103		84,680	6,794	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	686,836	17	29,058		84,680	3,583	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					$ 142,495	$		$ 17,569	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC		X				$	$			$ 199	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Private Bank		X	Line of Credit				1,200,000		4.00%	27,025	6
7				Insurance Policy							4,312	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 1,200,000			$ 31,536	9
	B. Non-Facility Related*											
10	Interest Income		X								(918)	10
11	Allocated from YAM Management										124	11
12	Allocated from 8131 N. Monticello										6,794	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 6,000	14
15	TOTALS (line 9+line14)						$	$ 1,200,000			$ 37,536	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.)**

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 300,000	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.)		$ 292,705	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,295)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 300,000	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.**		$ 38,600	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 331,305	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006		8
2007	334,567	9
2008	350,230	10
2009	531,054	11
2010	289,122	12

2011 R/E Tax Accrual = 1.03% X $289,122= $300,000
Allocated from 8131 N. Monticello- $3,583

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Berkshire Nursing And Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049247

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-24-100-020-0000	Long Term Care Property	$ 296,933.09	$ 296,933.09
2.	10-23-325-045-0000	Management Company	$ 35,987.49	$ 3,886.66
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 332,920.58	$ 300,819.75

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Berkshire Nursing And Rehab Center COUNTY Cook

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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? YES NO

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.

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from 8131 N. Monticello			$ 10,973	1
2					2
3	TOTALS			$ 10,973	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	15,031		20	833	833	3,625	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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
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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)		127,511	6,760		4,502	(2,258)	6,642	68
69	Financial Statement Depreciation			91,368			(91,368)		69
70	TOTAL (lines 4 thru 69)		$ 142,542	$ 98,128		$ 5,335	$ (92,793)	$ 10,267	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 142,542	$ 98,128		$ 5,335	$ (92,793)	$ 10,267	1
2	Vinyl Flooring	2008	14,327		20	955	955	3,821	2
3	Flooring	2008	5,625		20	375	375	1,469	3
4	Hardware And Installation Of Satellite Equipment	2008	6,200		20	1,240	1,240	4,443	4
5	Fence	2008	21,722		20	2,172	2,172	7,422	5
6	Wallcoverings, Paint Windows/Door Frames, Wallpaper	2008	8,510		20	851	851	2,908	6
7	Flooring	2008	11,213		20	748	748	2,679	7
8	Electrical Work	2008	2,750		20	275	275	917	8
9	Electrical Work	2008	2,475		20	248	248	825	9
10	Sign	2008	1,984		20	198	198	694	10
11	Wiring And Lighting	2008	2,440		20	244	244	773	11
12	Cable Wiring And Installation	2008	3,080		20	308	308	1,027	12
13	Flooring	2008	8,122		20	812	812	2,504	13
14	Swag With Cascade Valance	2008	3,244		20	324	324	1,000	14
15	Wallcoverings/Kitchenettes	2009	48,939		20	4,894	4,894	11,011	15
16	Valve Replacement	2009	5,226		20	261	261	675	16
17	Parking Lot Seal Coat	2009	6,360		20	318	318	769	17
18	Removal Of Existing Carpet; Installation Of Tile	2010	15,450		20	3,090	3,090	6,180	18
19	Windows, Bumper Guards, Flooring	2010	32,533		20	2,170	2,170	3,253	19
20	Circulating Pump	2010	3,149		20	630	630	1,155	20
21	Windows, Bumper Guards, Flooring - Deposit	2010	21,573		20	1,439	1,439	2,157	21
22	3Rd Floor-Kitchenette, Flooring, Window Treatments	2010	31,567		20	2,106	2,106	3,157	22
23	Bumper/Corner Guards, Glooring, Windows, Chandelier	2010	143,470		20	9,569	9,569	14,347	23
24	Water Heater	2011	34,880		20	2,664	2,664	2,664	24
25	New Condensor & Motor	2011	10,608		20	442	442	442	25
26	Security System-Cameras	2011	3,107		20	155	155	155	26
27	2Nd Flr Resident Rms-Flooring	2011	36,239		20	1,812	1,812	1,812	27
28	2Nd Flr Resident Rms-Bumper Gaurds,Assist Rails, Headboards,	2011	24,555		20	1,228	1,228	1,228	28
29	2Nd Flr Resident Rms-Painting	2011	18,056		20	903	903	903	29
30	2Nd Flr Resident Rms- Cubicle Curtains,Lighting, Electrical Wor	2011	24,838		20	1,242	1,242	1,242	30
31	Offices & Computer Room-Painting,Carpeting, Flooring	2011	14,943		20	747	747	747	31
32	Vestibule-Flooring,Wallcovering, Motion Doors	2011	31,591		20	1,580	1,580	1,580	32
33	Lobby-Wallvoverings, Lighting,Granite Ounter & Tiles	2011	11,137		20	557	557	557	33
34	TOTAL (lines 1 thru 33)		$ 752,453	$ 98,128		$ 49,892	$ (48,236)	$ 94,781	34

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: 01/01/11 Ending: 12/31/11

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		$ 752,453	$ 98,128		$ 49,892	$ (48,236)	$ 94,781	1
2	Atrium-Wallcoverings, Corner Gaurds	2011	5,655		20	283	283	283	2
3	Third Floor Corner Gaurds	2011	3,517		20	176	176	176	3
4	4Th Flr Resident Rms-Cubicle Curtains,Window Treatments,Corr	2011	21,452		20	1,073	1,073	1,073	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 783,077	$ 98,128		$ 51,423	$ (46,705)	$ 96,312	34

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: 01/01/11 Ending: 12/31/11

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		$ 783,077	$ 98,128		$ 51,423	$ (46,705)	$ 96,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 783,077	$ 98,128		$ 51,423	$ (46,705)	$ 96,312	34

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: 01/01/11 Ending: 12/31/11

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		$ 783,077	$ 98,128		$ 51,423	$ (46,705)	$ 96,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 783,077	$ 98,128		$ 51,423	$ (46,705)	$ 96,312	34

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: 01/01/11 Ending: 12/31/11

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	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
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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.

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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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

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: 01/01/11 Ending: 12/31/11

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	85,258	2,535	39	2,186	(349)	3,188	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from YAM Management	2010	4,062	406	20	406		517	9
10	Allocated from 8131 N. Monticello	2010	38,191	3,819	20	1,910	(1,909)	2,937	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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.

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 127,511	$ 6,760		$ 4,502	$ (2,258)	$ 6,642	34

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: 01/01/11 Ending: 12/31/11

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	$ 97,891	$ 1,344	$ 17,740	$ 16,396	10	$ 57,784	71
72	Current Year Purchases	96,046	14	12,999	12,985	10	13,000	72
73	Fully Depreciated Assets	28,137				10	28,137	73
74								74
75	TOTALS	$ 222,074	$ 1,358	$ 30,739	$ 29,381		$ 98,921	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		2009 GMC Caravan	2009	$	$	$ 2,893	$ 2,893		$	76
77		Allocated from YAM Managemer	2011	3,315	367	367		5	124	77
78										78
79										79
80	TOTALS			$ 3,315	$ 367	$ 3,260	$ 2,893		$ 124	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,019,439	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 99,853	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 85,422	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (14,431)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 195,357	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		232		$ 600,000			3
4	Additions							4
5								5
6								6
7	TOTAL		232		$ 600,000 **			7

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.	/2012	$ Based on Occupance
13.	/2013	$
14.	/2014	$

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: [X] 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: $ 1,752 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	Infinity/Honda/Toyota	$ 1080.49/550/320.55	$ 19,101	17
18	Allocated from YAM Consulting			7,634	18
19	Allocated from YAM Management			2,230	19
20					20
21	TOTAL		$	$ 28,965	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$		$ 270,598	$		$ 270,598	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			109,882			109,882	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			254,397			254,397	4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			413			413	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				286,140		286,140	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						46,513		46,513	13
14	TOTAL			$		$ 635,290	$ 332,653		$ 967,943	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

STATE OF ILLINOIS

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 836	$	1
2	Cash-Patient Deposits	60,908		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,975,760		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	208,390		6
7	Other Prepaid Expenses	2,100		7
8	Accounts Receivable (owners or related parties)	79,542		8
9	Other(specify): See Attached Schedule	764,393		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,091,929	$	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	703,715		15
16	Equipment, at Historical Cost	224,916		16
17	Accumulated Depreciation (book methods)	(202,136)		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	517,860		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,244,355	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,336,284	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 670,490	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,999		28
29	Short-Term Notes Payable	1,200,000		29
30	Accrued Salaries Payable	264,569		30
31	Accrued Taxes Payable (excluding real estate taxes)	71,531		31
32	Accrued Real Estate Taxes(Sch.IX-B)	300,000		32
33	Accrued Interest Payable	747		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	80,633		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,648,969	$	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)**	$ 2,648,969	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,687,315	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,336,284	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,919,211	1
2	Restatements (describe):		2
3	**Rounding Error**	(4)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,919,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,268,710	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	(500,602)	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)**	$ 768,108	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,687,315	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,998,188	1
2	Discounts and Allowances for all Levels	20,024	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,018,212	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,427,136	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,427,136	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	271,339	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,371	19
20	Radiology and X-Ray	4,025	20
21	Other Medical Services	14,498	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 315,233	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	918	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 918	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	21,622	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,622	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,783,121	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,270,770	31
32	Health Care	3,173,791	32
33	General Administration	2,238,761	33
	B. Capital Expense		
34	Ownership	1,055,659	34
	C. Ancillary Expense		
35	Special Cost Centers	1,648,410	35
36	Provider Participation Fee	127,020	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,514,411	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,268,710	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,268,710	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,724	1,890	$ 102,027	$ 53.98	1
2	Assistant Director of Nursing	1,869	2,050	72,030	35.14	2
3	Registered Nurses	12,398	13,118	403,729	30.78	3
4	Licensed Practical Nurses	33,749	37,347	904,684	24.22	4
5	CNAs & Orderlies	77,699	83,134	878,722	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,148	5,508	58,218	10.57	8
9	Activity Director	1,990	2,179	33,686	15.46	9
10	Activity Assistants	9,446	10,908	107,003	9.81	10
11	Social Service Workers	3,478	3,694	58,603	15.86	11
12	Dietician					12
13	Food Service Supervisor	1,982	2,224	30,717	13.81	13
14	Head Cook	6,007	6,464	68,780	10.64	14
15	Cook Helpers/Assistants	9,971	10,927	109,705	10.04	15
16	Dishwashers					16
17	Maintenance Workers	4,283	4,701	77,148	16.41	17
18	Housekeepers	19,769	21,413	203,045	9.48	18
19	Laundry	7,456	8,039	73,959	9.20	19
20	Administrator	1,364	1,569	104,878	66.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,670	15,171	171,720	11.32	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	5,738	6,283	161,517	25.71	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,574	3,937	115,253	29.27	33
34	TOTAL (lines 1 - 33)	224,315	240,556	$ 3,735,424 *	$ 15.53	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	647	$ 32,368	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	2,111	105,540	10-03	38
39	Pharmacist Consultant	Monthly	11,741	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	36	1,810	11-03	44
45	Social Service Consultant	65	3,245	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,860	$ 172,704		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Sklar (7/1/2011-current)	Administrator	0	$ 36,719
Benjamin Friedman (1/1/2011-7/1/2011)	Administrator	0	68,159
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,878

B. Administrative - Other

Description	Amount
Management Fees - Yosef Meystel	$ 27,000
Management Fees - David Berkowitz	43,000
YAM Administrative Consulting	29,196
TOTAL (agree to Schedule V, line 17, col. 3)	$ 99,196
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	MDS Software	$ 5,049
Admiral Environmental Services	Envirnomental Consulting	275
Personnel Planners	Unemployment Consulting	4,982
Prospect resources	Energy Procurement	1,200
First Real Estate Services	Real Estate Appraisal	2,750
Frost, Ruttenberg & Rothblatt	Accounting	38,750
See Attached	Legal	10,950
Health Data Systems	Data Processing	4,012
American Data	Data Processing	4,914
YAM Management	Data Processing	28,152
Professional Search Network	Recruitment	15,900
See Supplemetal Schedule		273,029
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 389,963

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,111
Unemployment Compensation Insurance	113,668
FICA Taxes	285,760
Employee Health Insurance	166,977
Employee Meals	1,008
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	24,874
Life Insurance	
Other Employee Benefits	15,045
TOTAL (agree to Schedule V, line 22, col.8)	$ 703,443

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,640
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 818	8,181
Dues & Subscriptions	20,837
Licenses & Permits	7,230
Allocated From YAM Mgmt	809
Allocated from YAM Consulting	105
See Supplemental Schedule	77
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,879

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	967
Allocated from YAM Consulting	476
Allocated from YAM Management	1,251
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,694

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Berkshire Nursing And Rehab Center # 0049247 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 $17,548**

(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. $ **26,100** 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. $ **127,020**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **1,008** 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 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.