FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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

I. IDPH License ID Number: 0049247

Facility Name: Berkshire Nrsing & Rehab Ctr

Address: 8200 W Roosevelt Rd (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: 7/1/2007

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 01/01/13 to 12/31/13 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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	8,451	79	12,046	20,576	8
9	SNF/PED					9
10	ICF	37,233	870	1,101	39,204	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,684	949	13,147	59,780	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.60%

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 11,744

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	220,538	33,492	40,795	294,825		294,825	(23,414)	271,411			1
2	Food Purchase		281,737		281,737		281,737	(45)	281,692			2
3	Housekeeping	240,177	27,394		267,571		267,571		267,571			3
4	Laundry	96,091	25,589		121,680		121,680		121,680			4
5	Heat and Other Utilities			281,768	281,768		281,768	(12,525)	269,243			5
6	Maintenance	57,167	39,672	138,994	235,833		235,833	16,709	252,542			6
7	Other (specify):*							3,121	3,121			7
8	TOTAL General Services	613,973	407,884	461,557	1,483,414		1,483,414	(16,154)	1,467,260			8
	B. Health Care and Programs											
9	Medical Director			38,000	38,000		38,000		38,000			9
10	Nursing and Medical Records	3,320,301	305,080	130,468	3,755,849		3,755,849	(51,354)	3,704,495			10
10a	Therapy	92,840	46,969		139,809		139,809		139,809			10a
11	Activities	173,262	10,688	2,080	186,030		186,030		186,030			11
12	Social Services	195,596		3,279	198,875		198,875		198,875			12
13	CNA Training											13
14	Program Transportation			115,212	115,212		115,212	4,129	119,341			14
15	Other (specify):*							9,327	9,327			15
16	TOTAL Health Care and Programs	3,781,999	362,737	289,039	4,433,775		4,433,775	(37,898)	4,395,877			16
	C. General Administration											
17	Administrative	162,329		98,548	260,877		260,877	38,474	299,351			17
18	Directors Fees											18
19	Professional Services			478,897	478,897	(44,773)	434,124	(231,300)	202,824			19
20	Dues, Fees, Subscriptions & Promotions			62,149	62,149		62,149	(17,755)	44,394			20
21	Clerical & General Office Expenses	148,538		405,709	554,247		554,247	(200,703)	353,544			21
22	Employee Benefits & Payroll Taxes			815,424	815,424		815,424		815,424			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,893	16,893		16,893	1,387	18,280			24
25	Other Admin. Staff Transportation			10,076	10,076		10,076	7,772	17,848			25
26	Insurance-Prop.Liab.Malpractice			392,645	392,645		392,645	2,584	395,229			26
27	Other (specify):*							44,606	44,606			27
28	TOTAL General Administration	310,867		2,280,341	2,591,208	(44,773)	2,546,435	(354,935)	2,191,500			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,706,839	770,621	3,030,937	8,508,397	(44,773)	8,463,624	(408,987)	8,054,637			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 Nrsing & Rehab Ctr #0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			178,860	178,860		178,860	(54,144)	124,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,621	43,621		43,621	1,061	44,682			32
33	Real Estate Taxes			497,580	497,580	44,773	542,353	6,447	548,800			33
34	Rent-Facility & Grounds			1,577,434	1,577,434		1,577,434	(12,000)	1,565,434			34
35	Rent-Equipment & Vehicles			25,536	25,536		25,536	6,698	32,234			35
36	Other (specify):*			15,487	15,487		15,487	(15,487)	0			36
37	TOTAL Ownership			2,338,518	2,338,518	44,773	2,383,291	(67,425)	2,315,866			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,578	1,822,042	1,831,620		1,831,620	(214,002)	1,617,618			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			346,675	346,675		346,675		346,675			42
43	Other (specify):*			551,574	551,574		551,574	(551,574)				43
44	TOTAL Special Cost Centers		9,578	2,720,291	2,729,869		2,729,869	(765,576)	1,964,293			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,706,839	780,199	8,089,746	13,576,784		13,576,784	(1,241,987)	12,334,797			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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	(14,156)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(62,222)	30		9
10	Interest and Other Investment Income	(6,205)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(45)	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	(2,034)	21		18
19	Entertainment	(7,740)	21		19
20	Contributions	(12,750)	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	(305,532)	21		24
25	Fund Raising, Advertising and Promotional	(24,036)	43		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	(599,705)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,034,424)		$	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)	(207,563)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (207,563)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,241,987)		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 **Page 5A**

Berkshire Nrsing & Rehab Ctr

ID# **0049247**

Report Period Beginning: **01/01/13**

Ending: **12/31/13**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (3,176)	21	1
2	Amortization	(15,487)	36	2
3	Theft & Damage Loss	(513)	21	3
4	Non-Allowable Fees	(515,109)	43	4
5	Jury Duty Income	(17)	21	5
6	Non-Allowable Legal	(23,268)	19	6
7	Additional R&M	26,348	06	7
8	COPE Dues	(9,701)	20	8
9	Rental Income	(10,933)	06	9
10	Non Allowable Professional Fees	(8,000)	19	10
11	Capitalized R&M	(7,515)	06	11
12	State Replacement Tax	(32,334)	21	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(599,705)		49

Berkshire Nrsing & Rehab Ctr

ID# 0049247

Report Period Beginning: 01/01/13

Ending: 12/31/13

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(23,414)								(23,414)	1
2	Food Purchase	(45)											(45)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,156)		1,631									(12,525)	5
6	Maintenance	7,900		2,861	5,948								16,709	6
7	Other (specify):*			244	2,877								3,121	7
8	**TOTAL General Services**	(6,301)		4,736	(14,589)								(16,154)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(51,354)								(51,354)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				4,129								4,129	14
15	Other (specify):*				9,327								9,327	15
16	**TOTAL Health Care and Programs**				(37,898)								(37,898)	16
	C. General Administration													
17	Administrative			38,718	(244)								38,474	17
18	Directors Fees													18
19	Professional Services	(31,268)		(167,897)	(29,398)	484	(3,221)						(231,300)	19
20	Fees, Subscriptions & Promotions	(22,451)		1,086	3,584	26							(17,755)	20
21	Clerical & General Office Expenses	(351,346)		122,020	28,413	210							(200,703)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			449	938								1,387	24
25	Other Admin. Staff Transportation			4,175	3,597								7,772	25
26	Insurance-Prop.Liab.Malpractice			2,144	440								2,584	26
27	Other (specify):*			32,646	11,960								44,606	27
28	**TOTAL General Administration**	(405,065)		33,341	19,290	720	(3,221)						(354,935)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(411,366)		38,077	(33,197)	720	(3,221)						(408,987)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(62,222)		2,617		5,461							(54,144)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,205)		2,156		5,110							1,061	32
33	Real Estate Taxes					6,447							6,447	33
34	Rent-Facility & Grounds			6,906		(18,906)							(12,000)	34
35	Rent-Equipment & Vehicles			2,815	3,883								6,698	35
36	Other (specify):*	(15,487)											(15,487)	36
37	**TOTAL Ownership**	(83,914)		14,494	3,883	(1,888)							(67,425)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(214,002)					(214,002)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(539,145)			(12,429)								(551,574)	43
44	**TOTAL Special Cost Centers**	(539,145)			(12,429)			(214,002)					(765,576)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,034,424)		52,571	(41,743)	(1,168)	(3,221)	(214,002)					(1,241,987)	45

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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%	$ 1,631	$ 1,631	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	2,861	2,861	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	244	244	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	38,718	38,718	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	6,990	6,990	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	1,086	1,086	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	122,020	122,020	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	449	449	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	4,175	4,175	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	2,144	2,144	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	32,646	32,646	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	2,617	2,617	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	2,156	2,156	27
28	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%			28
29	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	18,906	18,906	29
30	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	2,815	2,815	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	19	BOOKKEEPING FEES	138,887	YAM MANAGEMENT, LLC	100.00%		(138,887)	35
36	V	19	ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%		(36,000)	36
37	V	34	RENT	12,000	YAM MANAGEMENT, LLC	100.00%		(12,000)	37
38	V								38
39	Total			$ 186,887			$ 239,458	$ * 52,571	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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%	$ 17,381	$ 17,381	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	2,877	2,877	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	67,146	67,146	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	4,129	4,129	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	9,327	9,327	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	37,256	37,256	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	2,018	2,018	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	3,584	3,584	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	28,413	28,413	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	938	938	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	3,597	3,597	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	11,960	11,960	26
27	V	26	INSURANCE		YAM CONSULTING, LLC	100.00%	440	440	27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	3,883	3,883	28
29	V	6	REPAIRS AND MAINTENANCE SALARY		YAM CONSULTING, LLC	100.00%	7,628	7,628	29
30	V								30
31	V								31
32	V	06	PAINTER	480	YAM CONSULTING, LLC	100.00%		(480)	32
33	V	01	DIETICIAN CONSULTING	40,795	YAM CONSULTING, LLC	100.00%		(40,795)	33
34	V	10	NURSE CONSULTING	118,500	YAM CONSULTING, LLC	100.00%		(118,500)	34
35	V	17	DIR. OF OPERATIONS CONSULT	37,500	YAM CONSULTING, LLC	100.00%		(37,500)	35
36	V	19	DATA PROCESSING FEES	31,416	YAM CONSULTING, LLC	100.00%		(31,416)	36
37	V	43	MARKETING	12,429	YAM CONSULTING, LLC	100.00%		(12,429)	37
38	V	06	PROJECT MANAGER INCOME	1,200	YAM CONSULTING, LLC	100.00%		(1,200)	38
39	Total			$ 242,320			$ 200,577	$ * (41,743)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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%	$ 484	$ 484	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		26	26	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		210	210	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		5,461	5,461	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		5,110	5,110	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		6,447	6,447	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	18,906	8131 N. MONTICELLO, LLC			(18,906)	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			$ 18,906			$ 17,738	$ * (1,168)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Payroll Services	$ 24,775	ProPay HR LLC	66.67%	$ 21,554	$ (3,221)	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			$ 24,775			$ 21,554	$ * (3,221)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39	Therapy Services	$ 1,337,513	Renewal Rehab	100.00%	$ 1,123,511	$ (214,002)	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			$ 1,337,513			$ 1,123,511	$ * (214,002)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	26	INSURANCE	$ 213,000	ROOSEVELT RISK MANAGEMENT	100.00%	$ 213,000	$	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			$ 213,000			$ 213,000	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	42170 Limited Partnership	0.840%	EVANSTON NURSING & REHAB	EVANSTON	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	1219 Limited Partnership	0.830%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	257 Limited Partnership	0.830%	DOLTON NURSING & REHAB,LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	Marlee Associates, LLC	4.900%	EXCEPTIONAL CARE, LLC	BURBANK	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	David Kleiner	1.000%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Sarah Leiner	1.000%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO	ROOSEVELT RISK MANAGEME	SKOKIE	CAPTIVE INSURANCE	6
7	Declaration of Trust of Yosef Meystel	42.100%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				7
8	Mordechai Groner	1.000%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				8
9	Isaac Scheiner Ugma Rachel Scheiner	1.000%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				9
10	Jacob Scheiner Ugma Ari Scheiner	0.500%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				10
11	Jacob Scheiner Ugma Dov Scheiner	0.500%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				11
12	Jacob Scheiner Ugma Nosson Scheiner	0.500%	SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				12
13	David Berkowitz	42.000%	THE ARBORS AT MICHIGAN CITY	MICHIGAN CITY,IN				13
14	Joshua Weinstein	2.000%	THE COPPERAS HOLLOW	CALDWELL, TX				14
15	Christina Inofre	1.000%	ISLAND CITY REHAB CENTER	WILMINGTON				15
16			LINCOLN REHAB	DECATUR				16
17			RIVERWOOD REHAB	EAST MOLINE				17
18			RIVER CROSSING REHAB	GALESBURG				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Relative	Administrative	0.00%	See Attached	4.2	10.50%	Mgmt. Fees	$ 26,560	17-03	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	2.1	5.25%	Alloc. Salary	6,339	17-07	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	2.1	5.25%	Alloc. Salary	2,603	17-07	3
4	David Berkowitz	Owner	Administrative	42.00%	See Attached	4.2	10.50%	Mgmt. Fees	34,489	17-03	4
5	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.4	12.12%	Alloc. Salary	1,909	21-07	5
6	Christina Inofre	Owner	Nursing	1.00%	See Attached	4.2	10.50%	Alloc. Salary	11,557	10-07	6
7	Shimon Meystel	Relative	Clerical	0.00%	See Attached	4.2	10.50%	Alloc. Salary	900	21-07	7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 84,357		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	806,222	20	$ 15,532	$	84,680	$ 1,631	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	806,222	20	27,235	10,706	84,680	2,861	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	806,222	20	2,325		84,680	244	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	368,628	368,628	84,680	38,718	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	66,554		84,680	6,990	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	10,341		84,680	1,086	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	1,161,730	1,062,779	84,680	122,020	7
8	24	SEMINARS	AVAIL. BED DAYS	806,222	20	4,271		84,680	449	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	39,751		84,680	4,175	9
10	26	INSURANCE	AVAIL. BED DAYS	806,222	20	20,417		84,680	2,144	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	310,817		84,680	32,646	11
12	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	24,916		84,680	2,617	12
13	32	INTEREST	AVAIL. BED DAYS	806,222	20	20,530		84,680	2,156	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	806,222	20	-		84,680		14
15	34	RENT	AVAIL. BED DAYS	806,222	20	180,000		84,680	18,906	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	26,797		84,680	2,815	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,279,844	$ 1,442,113		$ 239,458	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	806,222	20	$ 165,484	$ 152,992	84,680	$ 17,381	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	806,222	20	27,395		84,680	2,877	2
3	10	NURSING SALARY	AVAIL. BED DAYS	806,222	20	639,288	639,288	84,680	67,146	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	806,222	20	39,307		84,680	4,129	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	806,222	20	88,801		84,680	9,327	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	354,711	354,711	84,680	37,256	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	19,212		84,680	2,018	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	34,122		84,680	3,584	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	270,517	258,772	84,680	28,413	9
10	24	SEMINARS	AVAIL. BED DAYS	806,222	20	8,935		84,680	938	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	34,250		84,680	3,597	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	113,873		84,680	11,960	12
13	26	INSURANCE	AVAIL. BED DAYS	806,222	20	4,192		84,680	440	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	36,968		84,680	3,883	14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	806,222	20	72,622	72,622	84,680	7,628	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,909,677	$ 1,478,385		$ 200,577	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	806,222	20	$ 4,605	$	84,680	$ 484	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	250		84,680	26	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	806,222	20	2,000		84,680	210	3
4	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	51,991		84,680	5,461	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	806,222	20	48,653		84,680	5,110	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	806,222	20	61,377		84,680	6,447	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					$ 168,876	$		$ 17,738	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: ProPay HR LLC
Street Address: 2201 W MAIN STREET
City / State / Zip Code: EVANSTON, ILLINOIS 60202
Phone Number: (847) 905-3268
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	19	Payorll Services	Direct			$	$		$ 21,554	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					$	$		$ 21,554	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Renewal Rehab	Direct			$	$		$ 1,123,511	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					$	$		$ 1,123,511	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: ROOSEVELT RISK MANAGEMENT
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	26	INSURANCE	DIRECT ALLOCATION			$	$		$ 213,000	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					$	$		$ 213,000	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				924,241			41,088	6
7				Insurance Policy							2,533	7
8												8
9	TOTAL Facility Related						$	$ 924,241			$ 43,621	9
	B. Non-Facility Related*											
10	Interest Income		X								(6,205)	10
11	Allocated from YAM Management										2,156	11
12	Allocated from 8131 N. Monticello										5,110	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,061	14
15	TOTALS (line 9+line14)						$	$ 924,241			$ 44,682	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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 352,742	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.)		$ 430,770	2
3. Under or (over) accrual (line 2 minus line 1).		$ 78,028	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 426,000	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.)**		$ 44,773	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 $ 38,875 For 2010 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.		$ 548,801	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	350,230	8
	2009	531,054	9
	2010	289,122	10
	2011	352,742	11
	2012	424,323	12

2013 R/E Tax Accrual = 2012 R/E Tax (rounded)
Allocated from 8131 N. Monticello- $6,447

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Berkshire Nrsing & Rehab Ctr 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 2012 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 2012.

	(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	$ 424,322.51	$ 424,322.51
2.	10-23-325-045-0000	Management Company	$ 70,066.20	$ 6,446.62
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 494,388.71	$ 430,769.13

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

IMPORTANT NOTICE

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

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

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

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Berkshire Nrsing & Rehab Ctr 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 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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Monticello		2010	$ 9,348	1
2					2
3	TOTALS			$ 9,348	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	5,291	9
10	Various			2008	91,691		20	8,027	8,027	47,257	10
11	Various			2009	60,525		20	5,473	5,473	23,401	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		116,860	5,976		4,287	(1,689)	13,857	68
69	Financial Statement Depreciation			178,860			(178,860)		69
70	TOTAL (lines 4 thru 69)		$ 284,107	$ 184,836		$ 18,620	$ (166,216)	$ 89,807	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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 284,107	$ 184,836		$ 18,620	$ (166,216)	$ 89,807	1
2	Removal Of Existing Carpet; Installation Of Tile	2010	15,450		20	3,090	3,090	12,360	2
3	Windows, Bumper Guards, Flooring	2010	32,533		20	2,170	2,170	7,593	3
4	Circulating Pump	2010	3,149		20	630	630	2,414	4
5	Windows, Bumper Guards, Flooring - Deposit	2010	21,573		20	1,439	1,439	5,035	5
6	3Rd Floor-Kitchenette, Flooring, Window Treatments	2010	31,567		20	2,106	2,106	7,368	6
7	Bumper/Corner Guards, Glooring, Windows, Chandelier	2010	143,470		20	9,569	9,569	33,486	7
8	Water Heater	2011	34,880		20	2,907	2,907	8,478	8
9	New Condensor & Motor	2011	10,608		20	1,061	1,061	2,563	9
10	Security System - Cameras	2011	3,107		20	155	155	362	10
11	2Nd Floor Resident Rooms - Flooring	2011	36,239		20	1,812	1,812	5,134	11
12	2Nd Floor Resident Rooms - Bumper Guards, Assist Rails, Headbo	2011	24,555		20	1,228	1,228	3,479	12
13	2Nd Floor Resident Rooms - Painting	2011	18,056		20	903	903	2,558	13
14	2Nd Floor Resident Rooms - Cubicle Curtains, Lighting, Electrical	2011	24,838		20	1,242	1,242	3,519	14
15	Offices & Computer Room - Painting, Carpeting, Flooring	2011	14,943		20	747	747	1,619	15
16	Vestibule - Flooring, Wallcovering, Motion Doors	2011	31,591		20	1,580	1,580	3,422	16
17	Lobby - Wallcoverings, Lighting, Granite Counter & Tiles	2011	11,137		20	557	557	1,207	17
18	Atrium - Wallcoverings, Corner Guards	2011	5,655		20	283	283	613	18
19	Third Floor Corner Guards	2011	3,517		20	176	176	381	19
20	4Th Floor Resident Rooms - Cubicle Curtains, Window Treatment	2011	21,452		20	1,073	1,073	2,324	20
21	Window Treatments	2012	2,793		20	559	559	885	21
22	Compressor Replacement	2012	27,437		20	1,829	1,829	2,744	22
23	Compressor Replacement	2012	24,438		20	1,629	1,629	2,172	23
24	Cleanup From Rtaa Burnout	2012	12,567		20	838	838	1,117	24
25	Rtaa Controll Panel	2012	5,430		20	362	362	498	25
26	Fire Pump	2012	3,495		20	233	233	262	26
27	Rebuild Boiler Pump	2012	2,597		20	130	130	260	27
28	Lined Panels And Cubicle Curtains	2012	44,827		20	2,241	2,241	4,482	28
29	Corridors: Install New Quarter Round And Paing Existing Base	2012	5,295		20	265	265	265	29
30	Conference Room: Remove Old Flooring And Replace With New C	2012	3,805		20	190	190	190	30
31	Kitchennette: Remove Old Flooring & Install New, Provide & Insta	2012	6,061		20	303	303	303	31
32	2 Elevators: Replace Flooring & Corner Gaurds	2012	3,122		20	156	156	156	32
33	2Nd Floor Sinage: Resident Rooms & Common Areas	2012	3,863		20	193	193	193	33
34	TOTAL (lines 1 thru 33)		$ 918,157	$ 184,836		$ 60,274	$ (124,562)	$ 207,248	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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 918,157	$ 184,836		$ 60,274	$ (124,562)	$ 207,248	1
2	2Nd & 3Rd Floor Offices: Remove Old And Replace Flooring	2012	3,317		20	166	166	166	2
3	2Nd Floor Shower Room: Complete Rehab: New Flooring, Tile, Dr	2012	44,187		20	2,209	2,209	2,209	3
4	3Rd Floor: Sinage For Resident Rooms & Common Areas	2012	4,574		20	229	229	229	4
5	3Rd Floor Nurses Station: Granite Trasnaction Tops, New Coverin	2012	20,720		20	1,036	1,036	1,036	5
6	3Rd Floor Corridor:Remove And Replace Flooring, New Hand Ra	2012	73,317		20	3,666	3,666	3,666	6
7	New Wall Covering For Following Areas: 3Rd Floor: Nurses Statio	2012	31,832		20	1,592	1,592	1,592	7
8	Door Replacement	2013	5,450		20	114	114	114	8
9	Plumbing Work	2013	2,800		20	70	70	70	9
10	Electrical Work	2013	3,784		20	126	126	126	10
11	Concrete Electrical Work	2013	14,950		20	125	125	125	11
12	Expansion Power Supply	2013	5,025		20	126	126	126	12
13	Fire Dampers	2013	3,978		20	199	199	199	13
14	Guest Bathrooms:Plumbing, Wall Tile & Flooring, Repair Drywall	2013	9,287		20	464	464	464	14
15	2Nd Floor Corridor: Sconces & Their Installation	2013	7,046		20	352	352	352	15
16	Rooms 204-211: Floor Work,Electrical Outlets, Lighting, Bumper	2013	25,894		20	1,295	1,295	1,295	16
17	Various Areas: Painting	2013	7,292		20	365	365	365	17
18	Physicians Lounge:Replace Flooring, Installation Of Kitchen Cabi	2013	11,381		20	569	569	569	18
19	2Nd Floor Nurses Station: Install Reatec On Nurses Station	2013	25,074		20	1,254	1,254	1,254	19
20	2Nd Floor Mds Office:Floor Prep, New Flooring	2013	2,858		20	143	143	143	20
21	2Nd Floor Theater: Remove Old Carpet And Install New	2013	10,614		20	531	531	531	21
22	3Rd Floor Dining Room: Lighting	2013	4,001		20	200	200	200	22
23	3Rd Floor Nurses Station: Bumper Rail	2013	3,007		20	150	150	150	23
24	Pump Repair	2013	5,265		20	263	263	263	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,243,808	$ 184,836		$ 75,516	$ (109,320)	$ 222,490	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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 1,243,808	$ 184,836		$ 75,516	$ (109,320)	$ 222,490	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,243,808	$ 184,836		$ 75,516	$ (109,320)	$ 222,490	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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 1,243,808	$ 184,836		$ 75,516	$ (109,320)	$ 222,490	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,243,808	$ 184,836		$ 75,516	$ (109,320)	$ 222,490	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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
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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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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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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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	72,633	2,160	35	1,862	(298)	6,441	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from YAM Management	2010	3,460	346	20	346		1,133	9
10	Allocated from YAM Management	2012	2,184	146	20	146		221	10
11	Allocated from YAM Management	2013	388	23	20	23		23	11
12	Allocated from 8131 N. Monticello	2010	32,536	3,254	20	1,627	(1,627)	5,756	12
13	Allocated from 8131 N. Monticello	2013	5,659	47	20	283	236	283	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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29									29
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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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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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31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 116,860	$ 5,976		$ 4,287	$ (1,689)	$ 13,857	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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 221,972	$ 1,098	$ 31,388	$ 30,290	10	$ 103,340	71
72	Current Year Purchases	139,984	243	17,052	16,809	10	17,052	72
73	Fully Depreciated Assets	54,488				10	54,488	73
74								74
75	TOTALS	$ 416,443	$ 1,341	$ 48,439	$ 47,098		$ 174,880	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from YAM Manageme	2011	$ 3,572	$ 761	$ 761	$	5	$ 1,795	76
77										77
78										78
79										79
80	TOTALS			$ 3,572	$ 761	$ 761	$		$ 1,795	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)	$ 1,673,171	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 186,938	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 124,716	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (62,222)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 399,165	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 1,565,434			3
4	Additions							4
5								5
6								6
7	TOTAL		232		$ 1,565,434 **			7

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

9. Option to Buy: [X] YES [ ] NO Terms: 19,720,000 *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 15,553 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Infiniti/Lexus	$ 1080.49/470	$ 9,985	17
18	Allocated from YAM Consulting			3,883	18
19	Allocated from YAM Management			2,815	19
20					20
21	TOTAL		$	$ 16,683	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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 470,044	$		$ 470,044	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			195,962			195,962	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			588,615			588,615	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			538,194			538,194	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					29,227	9,578		38,805	13
14	TOTAL			$		$ 1,822,042	$ 9,578		$ 1,831,620	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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	$ 24,040	$	1
2	Cash-Patient Deposits	175,553		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,951,818		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	289,847		6
7	Other Prepaid Expenses	9,865		7
8	Accounts Receivable (owners or related parties)	354,918		8
9	Other(specify): See Attached Schedule	440,752		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,246,793	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,247,092		15
16	Equipment, at Historical Cost	387,217		16
17	Accumulated Depreciation (book methods)	(493,399)		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	500,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,640,910	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,887,703	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,129,983	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	491,058		28
29	Short-Term Notes Payable	924,241		29
30	Accrued Salaries Payable	371,053		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,567		31
32	Accrued Real Estate Taxes(Sch.IX-B)	426,000		32
33	Accrued Interest Payable	4,391		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	81,829		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,443,122	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,443,122	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,444,581	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,887,703	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,172,916	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,172,916	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	154,715	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	(883,050)	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)**	$ (728,335)	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)**	$ 2,444,581	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,323,858	1
2	Discounts and Allowances for all Levels	(3,928,072)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,395,786	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,706,078	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,706,078	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	10,933	16
17	Sale of Drugs	489,851	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	49,125	19
20	Radiology and X-Ray	7,845	20
21	Other Medical Services	25,684	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 583,438	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	46,197	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 46,197	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,731,499	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,483,414	31
32	Health Care	4,433,775	32
33	General Administration	2,591,208	33
	B. Capital Expense		
34	Ownership	2,338,518	34
	C. Ancillary Expense		
35	Special Cost Centers	2,383,194	35
36	Provider Participation Fee	346,675	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,576,784	40
41	**Income before Income Taxes (line 30 minus line 40)****	154,715	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 154,715	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,143,277	44
45	Private Pay - Net Inpatient Revenue	188,690	45
46	Medicare - Net Inpatient Revenue	1,871,094	46
47	Other-(specify) Insurance	192,725	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,395,786	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2,008	2,080	$ 106,968	$ 51.43	1
2	Assistant Director of Nursing	3,280	3,495	131,794	37.71	2
3	Registered Nurses	17,818	19,136	574,381	30.02	3
4	Licensed Practical Nurses	46,800	50,323	1,378,606	27.40	4
5	CNAs & Orderlies	92,914	99,551	1,088,273	10.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,315	7,039	92,840	13.19	8
9	Activity Director	1,896	2,080	34,365	16.52	9
10	Activity Assistants	12,656	13,605	138,897	10.21	10
11	Social Service Workers	8,408	9,060	195,596	21.59	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,080	34,775	16.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,778	18,076	185,763	10.28	15
16	Dishwashers					16
17	Maintenance Workers	2,687	2,827	57,167	20.22	17
18	Housekeepers	20,029	21,887	240,177	10.97	18
19	Laundry	8,663	9,546	96,091	10.07	19
20	Administrator	2,024	2,080	127,595	61.34	20
21	Assistant Administrator	1,344	1,400	34,734	24.81	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,721	8,533	148,538	17.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,495	1,696	18,297	10.79	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,027	2,141	21,982	10.27	33
34	TOTAL (lines 1 - 33)	256,783	276,635	$ 4,706,839 *	$ 17.01	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	742	$ 40,795	01-03	35
36	Medical Director	Monthly	38,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,580	118,500	10-03	38
39	Pharmacist Consultant	Monthly	11,968	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	40	2,080	11-03	44
45	Social Service Consultant	62	3,279	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,424	$ 214,622		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

Facility Name & ID Number Berkshire Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Ulbert	Administrator	0.00%	$ 127,595
David Rosenberg	Asst. Admin	0.00%	24,038
Moshe Freedman	Admin in training	0.00%	10,696
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 162,329

B. Administrative - Other

Description	Amount
Management Fees - Yosef Meystel	$ 26,560
Management Fees - David Berkowitz	34,489
YAM Administrative Consulting	37,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 98,549
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
YAM Management	Bookeeping	$ 138,887
YAM Management	Data Processing	31,416
YAM Management	Accounting	36,000
Frost, Ruttenberg & Rothblatt	Accounting	15,075
Risk Management Seryces	Risk Management	2,000
Various	Legal	134,745
Clearview Healthcare	Adj pg 5a	8,000
Pro Payroll Solutions	Payroll	24,775
Blymas Tax Credit	WOTC	45
Personnel Planners	Unemployment Consulting	1,908
Admiral Enviromental Services	Enviromental Consulting	285
See Supplemental Schedule		85,760
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 478,895

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 135,403
Unemployment Compensation Insurance	123,854
FICA Taxes	359,107
Employee Health Insurance	175,378
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	13,412
401K Expense	1,423
Uniforms	6,073
Other Employee Benefits	774
TOTAL (agree to Schedule V, line 22, col.8)	$ 815,424

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	13,482
Health Care Worker Background Check	5,443
(Indicate # of checks performed 371)	
Patient Background Checks	
Dues & Subscriptions	16,454
Licenses & Permits	2,329
Allocated from YAM Consulting	3,584
Allocated from YAM Management	1,086
See Supplemental Schedule	26
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,394

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	16,893
Allocated from YAM Consulting	938
Allocated from YAM Management	449
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,280

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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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 Nrsing & Rehab Ctr # 0049247 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. **ILCLTC $17,324**

(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. $ **40,773** Line **10-02**

(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. $ **346,675**
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. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.