

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: <u>0047738</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Beecher Manor Nursing & Rehab Center, Llc</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>1201 Dixie Highway</u> <u>Beecher</u> <u>60401</u>			
Number City Zip Code			
County: <u>Will</u>			
Telephone Number: <u>(708)946-2600</u> Fax # <u>(708)946-9411</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>02/01/06</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Steve Lavenda</u>		Telephone Number: <u>(847) 236-1111</u>	
Email Address: _____			

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
Paid Preparer	(Title) _____	
	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Lisa M. Hanlon, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc

0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>130</u>	Skilled (SNF)	<u>130</u>	<u>47,450</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>130</u>	TOTALS	<u>130</u>	<u>47,450</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>27,786</u>	<u>6,936</u>	<u>7,805</u>	<u>42,527</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,786</u>	<u>6,936</u>	<u>7,805</u>	<u>42,527</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.62%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 02/01/2006

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 02/01/2006 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 128 and days of care provided 7,107

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

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

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

STATE OF ILLINOIS														
Facility Name & ID Number		Beecher Manor Nursing & Rehab Center, Llc				#	0047738		Report Period Beginning:		01/01/11	Ending:	Page 3	12/31/11
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)														
	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY				
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10			
	A. General Services													
1	Dietary	325,189	56,651	18,410	400,250		400,250	3,846	404,096				1	
2	Food Purchase		241,942		241,942		241,942	(13,679)	228,263				2	
3	Housekeeping	176,113	43,161		219,274		219,274	(1,299)	217,975				3	
4	Laundry		718	156,360	157,078		157,078		157,078				4	
5	Heat and Other Utilities			147,856	147,856		147,856	(12,478)	135,378				5	
6	Maintenance	102,606		131,963	234,569		234,569	4,754	239,323				6	
7	Other (specify):*							2,847	2,847				7	
8	TOTAL General Services	603,908	342,472	454,589	1,400,969		1,400,969	(16,009)	1,384,960				8	
	B. Health Care and Programs													
9	Medical Director			42,000	42,000		42,000		42,000				9	
10	Nursing and Medical Records	2,449,171	173,168	26,771	2,649,110		2,649,110	28,886	2,677,996				10	
10a	Therapy	200,179			200,179		200,179		200,179				10a	
11	Activities	118,224	23,656		141,880		141,880		141,880				11	
12	Social Services	142,460		1,830	144,290		144,290	5,123	149,413				12	
13	CNA Training												13	
14	Program Transportation												14	
15	Other (specify):*							8,394	8,394				15	
16	TOTAL Health Care and Programs	2,910,034	196,824	70,601	3,177,459		3,177,459	42,403	3,219,862				16	
	C. General Administration													
17	Administrative	93,954			93,954		93,954	40,519	134,473				17	
18	Directors Fees												18	
19	Professional Services			427,816	427,816		427,816	(350,860)	76,956				19	
20	Dues, Fees, Subscriptions & Promotions			18,574	18,574		18,574	(8,849)	9,725				20	
21	Clerical & General Office Expenses	100,212	44,008	83,624	227,844		227,844	94,380	322,224				21	
22	Employee Benefits & Payroll Taxes			637,661	637,661		637,661	(16,660)	621,001				22	
23	Inservice Training & Education												23	
24	Travel and Seminar			1,160	1,160		1,160	1,703	2,863				24	
25	Other Admin. Staff Transportation			5,006	5,006		5,006	371	5,377				25	
26	Insurance-Prop.Liab.Malpractice			129,113	129,113		129,113	826	129,939				26	
27	Other (specify):*							24,507	24,507				27	
28	TOTAL General Administration	194,166	44,008	1,302,954	1,541,128		1,541,128	(214,064)	1,327,064				28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,708,108	583,304	1,828,144	6,119,556		6,119,556	(187,669)	5,931,887				29	

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			63,789	63,789		63,789	292,546	356,335			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,850	2,850		2,850	474,646	477,496			32
33	Real Estate Taxes			140,033	140,033		140,033	1,375	141,408			33
34	Rent-Facility & Grounds			744,000	744,000		744,000	(744,000)				34
35	Rent-Equipment & Vehicles			4,707	4,707		4,707	(235)	4,472			35
36	Other (specify):*											36
37	TOTAL Ownership			955,379	955,379		955,379	24,331	979,710			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		561,811	751,437	1,313,248		1,313,248	(74,404)	1,238,844			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			233,432	233,432		233,432		233,432			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		561,811	984,869	1,546,680		1,546,680	(74,404)	1,472,276			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,708,108	1,145,115	3,768,392	8,621,615		8,621,615	(237,742)	8,383,873			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,296)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	52,809	30		9
10	Interest and Other Investment Income	(8,649)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(395)	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				18
19	Entertainment				19
20	Contributions	(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				24
25	Fund Raising, Advertising and Promotional	(10,869)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(28)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(39,651)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (19,829)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(217,913)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (217,913)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (237,742)		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

Report Period Beginning:

Ending:

ID#

0047738

01/01/11

12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Capitalized R&M	\$ (3,519)	6	1
2	Jury Duty Income	(34)	10	2
3	Theft Loss	(650)	21	3
4	Collection Expense	(3,115)	21	4
5	Prior Period Utility Deposit	(13,406)	05	5
6	Prior Period Professional Fees	(240)	19	6
7	Building Company - Amortization Expense	(11,567)	36	7
8	Building Company - Administrative Expenses	(250)	17	8
9	Out of Period Fees	(52)	21	9
10	Vending Income	(1,201)	02	10
11	Non-Allowable Legal	(5,617)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(39,651)		49

STATE OF ILLINOIS

Beecher Manor Nursing & Rehab Center, Llc

ID#

0047738

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			222		6,194		(2,570)					3,846	1
2	Food Purchase	(13,892)		213									(13,679)	2
3	Housekeeping			449		81			(1,829)				(1,299)	3
4	Laundry													4
5	Heat and Other Utilities	(13,406)		787		141							(12,478)	5
6	Maintenance	(3,519)		2,261	5,983	29							4,754	6
7	Other (specify):*				1,804	1,043							2,847	7
8	TOTAL General Services	(30,817)		3,932	7,787	7,488		(2,570)	(1,829)				(16,009)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)				34,563			(5,643)				28,886	10
10a	Therapy													10a
11	Activities													11
12	Social Services					5,123							5,123	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,680	1,714						8,394	15
16	TOTAL Health Care and Programs	(34)				46,366	1,714		(5,643)				42,403	16
	C. General Administration													
17	Administrative	(250)	250	2,362	8,041	30,116							40,519	17
18	Directors Fees													18
19	Professional Services	(5,857)		(269,305)		(75,698)							(350,860)	19
20	Fees, Subscriptions & Promotions	(11,619)		2,644		126							(8,849)	20
21	Clerical & General Office Expenses	(3,845)		9,794	82,201	6,230							94,380	21
22	Employee Benefits & Payroll Taxes				(14,914)		(1,714)		(32)				(16,660)	22
23	Inservice Training & Education													23
24	Travel and Seminar			146		1,557							1,703	24
25	Other Admin. Staff Transportation			371									371	25
26	Insurance-Prop.Liab.Malpractice			704		122							826	26
27	Other (specify):*				18,775	5,732							24,507	27
28	TOTAL General Administration	(21,571)	250	(253,284)	94,103	(31,815)	(1,714)		(32)				(214,064)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,422)	250	(249,352)	101,890	22,039		(2,570)	(7,504)				(187,669)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	52,809	230,970	7,602		1,165							292,546	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,649)	476,460	6,466		369							474,646	32
33	Real Estate Taxes			1,166		209							1,375	33
34	Rent-Facility & Grounds		(744,000)										(744,000)	34
35	Rent-Equipment & Vehicles			2,881						(3,116)			(235)	35
36	Other (specify):*	(11,567)	11,567											36
37	TOTAL Ownership	32,593	(25,003)	18,115		1,743				(3,116)			24,331	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(6,044)	(5,014)	(25,118)	(37,575)	(654)	(74,404)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers							(6,044)	(5,014)	(25,118)	(37,575)	(654)	(74,404)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(19,829)	(24,753)	(231,237)	101,890	23,782		(8,614)	(12,518)	(28,234)	(37,575)	(654)	(237,742)	45

VII. RELATED PARTIES

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

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

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 744,000	Beecher Properties, LLC	100.00%	\$	(744,000)	1
2	V	33	Real Estate Taxes	140,033	Beecher Properties, LLC	100.00%	140,033		2
3	V	17	Administrative Expenses		Beecher Properties, LLC	100.00%	250	250	3
4	V	30	Depreciation		Beecher Properties, LLC	100.00%	230,970	230,970	4
5	V	36	Amortization		Beecher Properties, LLC	100.00%	11,567	11,567	5
6	V	32	Interest Expense		Beecher Properties, LLC	100.00%	476,460	476,460	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 884,033			\$ 859,280	\$ * (24,753)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 222	\$ 222	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	213	213	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	449	449	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	787	787	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,261	2,261	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,362	2,362	20
21	V	19	Professional Fees	273,720	Extended Care Consulting, LLC	100.00%	4,415	(269,305)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,644	2,644	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	9,794	9,794	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	146	146	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	371	371	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	704	704	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	7,602	7,602	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	6,466	6,466	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,166	1,166	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,881	2,881	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 273,720			\$ 42,483	\$ * (231,237)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	5,983	\$ 5,983	15
16	V	06	Maintenance (Direct)	5,482	Extended Care Consulting, LLC	100.00%	5,482		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,073	1,073	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	731	731	18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,041	8,041	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	82,201	82,201	22
23	V	21	Office and Clerical (Direct)	31,329	Extended Care Consulting, LLC	100.00%	31,329		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	15,527	15,527	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,248	3,248	25
26	V	22	Employee Benefits	14,914	Extended Care Consulting, LLC	100.00%		(14,914)	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			\$ 51,725			\$ 153,615	\$ * 101,890	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 81	\$ 81	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	141	141	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	29	29	17
18	V	19	Professional Fees	91,236	Extended Care Clinical, LLC	100.00%	15,538	(75,698)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	126	126	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,296	2,296	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,557	1,557	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	122	122	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,165	1,165	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	369	369	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	209	209	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	6,194	6,194	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,043	1,043	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	34,563	34,563	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%			29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	5,123	5,123	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,680	6,680	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	30,116	30,116	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	3,934	3,934	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,732	5,732	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 91,236			\$ 115,018	\$ * 23,782	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	\$	Extended Care Clinical, LLC	100.00%	\$	\$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing / Medical Record Salary	13,784	Extended Care Clinical, LLC	100.00%	13,784		17
18	V	12	Social Service / Admission Salary	1,314	Extended Care Clinical, LLC	100.00%	1,314		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	1,714	1,714	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	1,714	Extended Care Clinical, LLC	100.00%		(1,714)	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			\$ 16,812			\$ 16,812	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Supplies, Supplements	\$ 5,364	Care Centers Health Systems, Inc.	100.00%	\$ 2,793	\$ (2,570)	15
16	V	2	Food		Care Centers Health Systems, Inc.	100.00%			16
17	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			17
18	V	39	Ancillary Expense	12,611	Care Centers Health Systems, Inc.	100.00%	6,567	(6,044)	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			\$ 17,974			\$ 9,360	\$ * (8,614)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Xcel Supply, LLC	100.00%	\$	\$	15
16	V	3	Housekeeping	30,166	Xcel Supply, LLC	100.00%	28,338	(1,829)	16
17	V	4	Laundry		Xcel Supply, LLC	100.00%			17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	93,080	Xcel Supply, LLC	100.00%	87,437	(5,643)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits	534	Xcel Supply, LLC	100.00%	501	(32)	22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	82,709	Xcel Supply, LLC	100.00%	77,695	(5,014)	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			\$ 206,489			\$ 193,971	\$ * (12,518)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ventilator Equipment	38,100	Vent Lease LLC	100.00%	12,982	(25,118)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	3,116	Vent Lease LLC	100.00%		(3,116)	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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 260,326	260,326	27
28	V								28
29	V								29
30	V								30
31	V	22	Employee Health Insurance	260,326	CCS Employee Benefits Group	100.00%		(260,326)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 301,542			\$ 273,308	\$ * (28,234)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	\$ 668,997	TriCare Rehab	100.00%	\$ 631,422	\$ (37,575)	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			\$ 668,997			\$ 631,422	\$ * (37,575)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	R&M - Equipment	\$	Reliable Medical of the Midwest, LLC	100.00%	\$	\$	15
16	V	10	Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39	Ancillary Expense	73,148	Reliable Medical of the Midwest, LLC	100.00%	72,494	(654)	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			\$ 73,148			\$ 72,494	\$ * (654)	39

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	ERIC ROTHNER	0.500%			BEECHER PROPERTIES, LLC	EVANSTON	BUILDING CO.	1
2	GALE ROTHNER	0.500%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKING	2
3	ROTHNER FAMILY GRANCHILDREN TRUST	99.000%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BRIAR PLACE, LTD.	INDIAN HEAD	CARE CENTER HEALTH SYSTEM	DES PLAINES	DIETARY & FOOD SUPPLY	4
5			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	CCS EMPLOYEE BENEFITS GROUP	EVANSTON	HEALTH INSURANCE	5
6			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	6
7			DYER NURSING & REHAB	DYER, IN	VENTLEASE, LLC	EVANSTON	VENTILATOR RENTAL	7
8			GRASMERE PLACE, LLC	CHICAGO	TRICARE REHAB	HILLSDALE	THERAPY	8
9			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET	RELIABLE MEDICAL SUPPLY COMPANY	DES PLAINES	MEDICAL SUPPLY	9
10			HOMESTEAD NURSING & REHAB	LINCOLN, NE	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	10
11			GOLDEN PLANES	HUTCHINSON, KS				11
12			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				12
13			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				13
14			LANCASTER MANOR	LINCOLN, NE				14
15			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				15
16			MCKINLEY HEALTH CARE CENTER	CANTON, OH				16
17			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				17
18			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				18
19			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				19
20			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				20
21			RAINBOW BEACH QOC, L.L.C.	CHICAGO				21
22			SEBOS NURSING & REHAB	HOBART, IN				22
23								23
24			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				24
25			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				25
26			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				26
27			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				27
28			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				28
29			WHEATON CARE CENTER	WHEATON				29
30								30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, LI # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	G. Matt Silvers	Relative	Administrative	0%	See Attached	0.66	1.65%	Alloc. Salary	\$ 2,589	17-7	1
2	Adam Vales	Relative	Clerical	0%	See Attached	1.92	4.80%	Alloc. Salary	3,397	22-7	2
3	Mark Steinberg	Relative	Administrative	0%	See Attached	2.8	5.09%	Al. Sal/Al. Fees	9,167	17-7	3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only										9
10	amounts anticipated to be considered allowable by the Illinios Department of Health and Family Services.										10
11											11
12											12
13								TOTAL	\$ 15,153		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 Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,332,501	31	\$ 6,942	\$	42,527	\$ 222	1
2	02	Food	Patient Days	1,332,501	31	6,677		42,527	213	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		42,527	449	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		42,527	787	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		42,527	2,261	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		42,527	2,362	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		42,527	4,415	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		42,527	2,644	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		42,527	9,794	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		42,527	146	10
11	25	Other Staff Admin. Trans.	Patient Days	1,332,501	31	11,637		42,527	371	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		42,527	704	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		42,527	7,602	13
14	32	Interest	Patient Days	1,332,501	31	202,602		42,527	6,466	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		42,527	1,166	15
16	34	Rent - Building	Patient Days	1,332,501	31			42,527		16
17	35	Rent - Equipment & Auto	Patient Days	1,332,501	31	90,286		42,527	2,881	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,331,096	\$		\$ 42,483	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	06	Maintenance (Pooled)	Patient Days	1,332,501	31	187,474	187,474	42,527	5,983	1
2	06	Maintenance (Direct)	Direct		31	122,603	122,603		5,482	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,332,501	31	33,619		42,527	1,073	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	16,441			731	4
5	12	Admission (Direct)	Direct		31					5
6	15	Emp. Ben. - Nursing (Direct)	Direct		31					6
7	17	Administrative (Pooled)	Patient Days	1,332,501	31	251,959	251,959	42,527	8,041	7
8	21	Office and Clerical (Pooled)	Patient Days	1,332,501	31	2,575,611	2,575,611	42,527	82,201	8
9	21	Office and Clerical (Direct)	Direct		31	545,076	545,076		31,329	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,332,501	31	486,522		42,527	15,527	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	78,893			3,248	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					\$ 4,298,198	\$ 3,682,723		\$ 153,615	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Clinical, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	03	Housekeeping	Patient Days	817,528	19	\$ 1,549	\$	42,527	\$ 81	1
2	05	Utilities	Patient Days	817,528	19	2,718		42,527	141	2
3	06	Maintenance	Patient Days	817,528	19	557		42,527	29	3
4	19	Professional Fees	Patient Days	817,528	19	298,695		42,527	15,538	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426		42,527	126	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146		42,527	2,296	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934		42,527	1,557	7
8	26	Insurance	Patient Days	817,528	19	2,346		42,527	122	8
9	30	Depreciation	Patient Days	817,528	19	22,389		42,527	1,165	9
10	32	Interest	Patient Days	817,528	19	7,100		42,527	369	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024		42,527	209	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	119,073	42,527	6,194	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044		42,527	1,043	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	664,429	42,527	34,563	14
15	10a	Rehab Salary	Patient Days	817,528	19			42,527		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	98,474	42,527	5,123	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421		42,527	6,680	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	578,938	42,527	30,116	18
19	21	Office Salary	Patient Days	817,528	19	75,625	75,625	42,527	3,934	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184		42,527	5,732	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,211,073	\$ 1,536,540		\$ 115,018	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Clinical, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Direct Allocation			\$	\$		\$	1
2	07	Emp. Ben. - General	Direct Allocation							2
3	10	Nursing / Medical Record Salary	Direct Allocation			344,209	344,209		13,784	3
4	12	Social Service / Admission Salary	Direct Allocation			174,668	174,668		1,314	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			61,656			1,714	5
6	17	Administration Salary	Direct Allocation							6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation							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					\$ 580,533	\$ 518,877		\$ 16,812	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Health Systems, Inc.
Street Address 200 Howard
City / State / Zip Code Des Plaines, Illinois 60018
Phone Number (224) 612-5662
Fax Number (224) 612-5862

	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	Dietary Supplies, Supplements	Direct Allocation			\$	\$		2,793	1
	2	Food	Direct Allocation							2
	3	Nursing Supplies	Direct Allocation							3
	4	Ancillary Expense	Direct Allocation						6,567	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				\$	\$		9,360	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Xcel Supply, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, IL 60202
Phone Number (847)328-7600
Fax Number (847)328-7615

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary	Direct Allocation			\$	\$		\$	1
2	3	Housekeeping	Direct Allocation						28,338	2
3	4	Laundry	Direct Allocation							3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						87,437	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation						501	8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation						77,695	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					\$	\$		193,971	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Vent Lease, LLC / CCS Employee Ben. Group, In
Street Address 2201 W. Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 674-1180 / (847)905-4000
Fax Number (847) 673-7741 / (847)905-4040

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	39	Ventilator Equipment	Direct Allocation						12,982	1
2	39	Other Ancillary	Direct Allocation							2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 260,326	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					\$	\$		\$ 273,308	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization TriCare Rehab
Street Address 150 Fencel Lane
City / State / Zip Code Hillside, IL 60162
Phone Number (773) 449-9400
Fax Number (773) 449-9700

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	39	Therapy	Direct Allocation		\$	\$		\$ 631,422	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				\$	\$		\$ 631,422	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Reliable Medical of the Midwest, LLC
Street Address 200 Howard Avenue
City / State / Zip Code Des Plaines, Illinois 60018-5909
Phone Number (847) 566-0800
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	R&M - Equipment	Direct Allocation			\$	\$		\$	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						72,494	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					\$	\$		\$ 72,494	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Central Illinois Bank		X	Mortgage			\$	7,709,665			\$	476,460	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Central Illinois Bank		X	Line of Credit								2,391	6
7	Xerox		X	Note Payable				2,695				459	7
8	See Supplemental Schedule											6,835	8
9	TOTAL Facility Related						\$	7,712,360			\$	486,145	9
	B. Non-Facility Related*												
10	Interest Income											(8,649)	10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(8,649)	14
15	TOTALS (line 9+line14)						\$	7,712,360			\$	477,496	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	EC Consulting Allocation	X					\$	\$			\$ 6,466	8	
9	EC Clinical Allocation	X									369	9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										6,835	14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	136,744	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.)				\$	136,388	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(356)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	141,764	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	141,408	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2006	51,697	8			
	2007	50,648	9			
	2008	49,999	10			
	2009	130,233	11			
	2010	135,013	12			
2011 Accrual = \$135,013 x 1.05 = \$141,764						
Allocated from Extended Care Clinical 2201: \$209						
Allocated from Extended Care Consulting 2201: \$1,166						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beecher Manor Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0047738

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>22-22-16-200-028-0000</u>	<u>Long Term Care Property</u>	\$ <u>131,414.70</u>	\$ <u>131,414.70</u>
2.	<u>22-22-16-200-021-0000</u>	<u>Long Term Care Property</u>	\$ <u>3,598.56</u>	\$ <u>3,598.56</u>
3.	<u>See Attached</u>	<u>Allocation from 2201 Main</u>	\$ <u>126,481.18</u>	\$ <u>1,919.60</u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>261,494.44</u>	\$ <u>136,932.86</u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beecher Manor Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0047738

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. **Real Estate Tax Cost Allocations**

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,799

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	123,116	2006	\$ 163,718	1
2	Allocated from EC Consulting 2201/Clinical 2201			12,445	2
3	TOTALS	123,116		\$ 176,163	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	130		2006	1985	\$ 2,546,584	\$ 65,297	39	\$ 65,297	\$ 0	\$ 383,619	4
5				2008	1,794,872	46,021	39	46,022	1	155,349	5
6				2009	3,653,332	92,770	39	93,675	905	267,745	6
7				2009	(35,175)						7
8				2010	4,953	127	39	122	(5)	244	8
	Improvement Type**										
9	Various			2006	44,583		20	2,229	2,229	12,028	9
10	Various			2007	35,433		20	2,164	2,164	10,256	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		50,398	3,425		3,425		27,326	68
69	Financial Statement Depreciation			63,789			(63,789)		69
70	TOTAL (lines 4 thru 69)		\$ 8,094,980	\$ 271,429		\$ 212,934	\$ (58,495)	\$ 856,568	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc

0047738

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,094,980	\$ 271,429		\$ 212,934	\$ (58,495)	\$ 856,568	1
2	Cable For Phones	2008	4,236		20	212	212	830	2
3	Phone System	2008	16,471		20	824	824	3,157	3
4	Call System	2008	1,142		20	57	57	219	4
5	Door Alert System	2008	5,555		20	278	278	1,065	5
6	Shower Floors	2008	7,563		20	378	378	1,418	6
7	Shower Floors	2008	7,536		20	377	377	1,413	7
8	Shower Floors	2008	5,042		20	252	252	924	8
9	Call System	2008	8,177		20	409	409	1,499	9
10	Cocerhead Light Switches	2008	3,500		20	175	175	642	10
11	Lock Systems	2008	3,141		20	157	157	576	11
12	Blinds	2008	4,266		20	427	427	1,493	12
13	Shower Stalls	2008	5,042		20	252	252	882	13
14	Sprinkler Placard	2008	3,500		20	175	175	569	14
15	Telephone Wiring	2008	6,596		20	330	330	1,072	15
16	Fire Panel	2008	2,550		20	128	128	414	16
17	Paint	2008	3,072		20	154	154	499	17
18	Nurse Call System	2008	2,983		20	149	149	485	18
19	Magnetic Locks	2008	3,587		20	179	179	583	19
20	Painting (Transfer From Home Office)	2008	6,063		20			6,063	20
21	Painting (Transfer From Home Office)	2008	7,345		20			7,345	21
22	Painting	2009	7,481		20			7,481	22
23	Phone System	2009	37,191		20	7,438	7,438	22,315	23
24	Generator Repair	2009	3,601		20	180	180	540	24
25	Painting	2009	3,335		20			3,335	25
26	Alarm Repairs	2009	2,910		20	146	146	437	26
27	Blinds	2009	4,050		20	810	810	2,430	27
28	Curtains	2009	3,968		20	794	794	2,381	28
29	Painting	2009	8,050		20			8,050	29
30	Painting	2009	19,007		20			19,007	30
31	Air Conditioners	2009	4,995		20	250	250	624	31
32	Remodel 5 Res. Rooms - Walls, Plumbing, Flooring	2009	13,640		20	682	682	1,591	32
33	Window	2009	5,640		20	282	282	635	33
34	TOTAL (lines 1 thru 33)		\$ 8,316,215	\$ 271,429		\$ 228,427	\$ (43,002)	\$ 956,540	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,316,215	\$ 271,429		\$ 228,427	\$ (43,002)	\$ 956,540	1
2	Upgrade Boilers	2010	3,893		20	195	195	389	2
3	2 New Doors	2010	2,595		20	130	130	195	3
4	Circulator Pump & Electronic Ballist	2010	3,128		20	626	626	782	4
5	Retrofit 3 Pilots For Electronic Ignition	2010	4,094		20	205	205	239	5
6	Replace Ceiling Tiles Damaged By Storm	2010	4,063		20	203	203	305	6
7	Roof Repair - Epdm Patching	2010	2,500		20	125	125	198	7
8	Painting	2011	3,519		20	3,226	3,226	3,226	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,340,006	\$ 271,429		\$ 233,135	\$ (38,294)	\$ 961,873	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,340,006	\$ 271,429		\$ 233,135	\$ (38,294)	\$ 961,873	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,340,006	\$ 271,429		\$ 233,135	\$ (38,294)	\$ 961,873	34

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,340,006	\$ 271,429		\$ 233,135	\$ (38,294)	\$ 961,873	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)		\$ 8,340,006	\$ 271,429		\$ 233,135	\$ (38,294)	\$ 961,873	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc

0047738

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main, LLC	2002	14,539	373	39	373		3,464	3
4	Allocated from Extended Care Clinical 2201 Main, LLC	2002	2,611	67	39	67		622	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	147	7	20	7		37	9
10	Allocated from Extended Care Consulting, LLC	2009	88	4	20	4		13	10
11	Allocated from Extended Care Consulting, LLC	2010	861	43	20	43		86	11
12	Allocated from Extended Care Consulting, LLC	2011	310	15	20	15		15	12
13									13
14	Allocated from Extended Care Consulting 2201 Main, LLC	2002	12,011	1,098	20	1,098		8,792	14
15	Allocated from Extended Care Consulting 2201 Main, LLC	2003	14,154	1,294	20	1,294		10,361	15
16	Allocated from Extended Care Consulting 2201 Main, LLC	2005	703	75	20	75		403	16
17	Allocated from Extended Care Consulting 2201 Main, LLC	2009	127	6	20	6		19	17
18									18
19	Allocated from Extended Care Clinical 2201 Main, LLC	2002	2,157	197	20	197		1,579	19
20	Allocated from Extended Care Clinical 2201 Main, LLC	2003	2,541	232	20	232		1,860	20
21	Allocated from Extended Care Clinical 2201 Main, LLC	2005	126	13	20	13		72	21
22	Allocated from Extended Care Clinical 2201 Main, LLC	2009	23	1	20	1		3	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 50,398	\$ 3,425		\$ 3,425	\$	\$ 27,326	34

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$595,623	\$27,551	\$115,778	\$88,227	10	\$608,953	71
72	Current Year Purchases	59,248	3,804	6,680	2,876	10	33,636	72
73	Fully Depreciated Assets	109,009				10	109,009	73
74								74
75	TOTALS	\$763,880	\$31,355	\$122,458	\$91,103		\$751,598	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 Extended Care Cc	2011	\$10,263	\$160	\$160		5	\$10,102	76
77		Allocated from Extended Care Cl	2011	2,908	582	582		5	1,938	77
78										78
79										79
80	TOTALS			\$13,171	\$742	\$742			\$12,040	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$9,293,221	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$303,526	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$356,335	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$52,809	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,725,511	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	Design Plan for Addition	\$86,109	92
93			93
94			94
95		\$86,109	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 4,472
- 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 281,792	\$		\$ 281,792	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			110,506			110,506	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			276,699			276,699	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				298,671		298,671	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					82,440	263,140		345,580	13
14	TOTAL			\$		\$ 751,437	\$ 561,811		\$ 1,313,248	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 79,869	\$ 88,855	1
2	Cash-Patient Deposits	26,451	26,451	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,199,425	2,199,425	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	218,785	218,785	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	838,493	613,152	8
9	Other(specify): See Attached Schedule	453,781	453,781	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,816,804	\$ 3,600,449	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		163,718	13
14	Buildings, at Historical Cost		7,964,566	14
15	Leasehold Improvements, at Historical Cost	328,092	328,092	15
16	Equipment, at Historical Cost	272,463	704,161	16
17	Accumulated Depreciation (book methods)	(279,881)	(1,517,633)	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		68,729	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 320,674	\$ 7,711,633	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,137,478	\$ 11,312,082	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,221,734	\$ 1,221,734	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,580	17,580	28
29	Short-Term Notes Payable	1,387	1,387	29
30	Accrued Salaries Payable	244,159	244,159	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,259	11,259	31
32	Accrued Real Estate Taxes(Sch.IX-B)	141,764	141,764	32
33	Accrued Interest Payable		39,849	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,637,883	\$ 1,677,732	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,308	1,308	39
40	Mortgage Payable		7,709,665	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,308	\$ 7,710,973	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,639,191	\$ 9,388,705	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,498,287	\$ 1,923,377	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,137,478	\$ 11,312,082	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 942,886	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 942,886	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,555,401	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,555,401	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)	\$ 2,498,287	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,830,195	1
2	Discounts and Allowances for all Levels	(3,415,975)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,414,220	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,910,614	6
7	Oxygen	29,737	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,940,351	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	3,114	13
14	Non-Patient Meals	12,296	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	304,598	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	58,126	19
20	Radiology and X-Ray	2,370	20
21	Other Medical Services	427,116	21
22	Laundry	4,941	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 812,561	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,649	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,649	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,235	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,235	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,177,016	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,400,969	31
32	Health Care	3,177,459	32
33	General Administration	1,541,128	33
	B. Capital Expense		
34	Ownership	955,379	34
	C. Ancillary Expense		
35	Special Cost Centers	1,313,248	35
36	Provider Participation Fee	233,432	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,621,615	40
41	Income before Income Taxes (line 30 minus line 40)**	1,555,401	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,555,401	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,025	2,182	\$ 86,256	\$ 39.53	1
2	Assistant Director of Nursing	1,932	1,971	79,362	40.26	2
3	Registered Nurses	22,198	24,749	740,926	29.94	3
4	Licensed Practical Nurses	22,224	25,506	585,503	22.96	4
5	CNAs & Orderlies	71,487	77,882	891,743	11.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,884	11,205	200,179	17.87	8
9	Activity Director	1,797	2,130	49,227	23.11	9
10	Activity Assistants	6,569	7,027	68,997	9.82	10
11	Social Service Workers	7,151	7,698	142,460	18.51	11
12	Dietician	1,025	1,143	17,323	15.16	12
13	Food Service Supervisor	1,988	2,302	62,392	27.10	13
14	Head Cook	2,743	3,076	36,872	11.99	14
15	Cook Helpers/Assistants	20,833	23,412	208,602	8.91	15
16	Dishwashers					16
17	Maintenance Workers	4,801	5,230	102,606	19.62	17
18	Housekeepers	16,928	17,887	176,113	9.85	18
19	Laundry					19
20	Administrator	1,947	2,115	93,954	44.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,170	7,725	100,212	12.97	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	1,962	2,153	35,807	16.63	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,685	1,950	29,574	15.17	33
34	TOTAL (lines 1 - 33)	206,349	227,343	\$ 3,708,108 *	\$ 16.31	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	361	\$ 18,410	01-03	35
36	Medical Director	Monthly	42,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,700	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				44
45	Social Service Consultant	9	516	12-03	45
46	Other(specify)				46
47	See Attached		15,097		47
48					48
49	TOTAL (lines 35 - 48)	370	\$ 83,723		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6	\$ 372	10-03	50
51	Licensed Practical Nurses	11	396	10-03	51
52	Certified Nurse Assistants/Aides	349	4,519	10-03	52
53	TOTAL (lines 50 - 52)	366	\$ 5,287		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Michael K. Garner	Administrator	0	\$ 93,954
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,954
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Frost, Ruttenberg & Rothblatt	Accounting	\$	25,100
Personnel Planners	Unemployment Tax		1,900
Adjusted Page 5A	Legal		5,617
Various	Legal		3,319
Extended Care Consulting	Home Office Expense		273,720
Extended Care Clinical	Home Office Expense		91,236
Prospect Resources	Energy Consultant		922
Blymas, Inc.	Tax Credit Services		2,171
Pinnacle Consulting	Cust. & EE Satisfaction Prgrm		2,390
ECC	Various		2,214
Paycor	Payroll Services		11,486
See Supplemental Schedule			7,740
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 427,815
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	117,327
Unemployment Compensation Insurance			78,279
FICA Taxes			253,866
Employee Health Insurance			148,052
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Physicals			8,214
Other Employee Welfare			12,714
Holiday Expense			2,550
TOTAL (agree to Schedule V, line 22, col.8)			\$ 621,000
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			376
Health Care Worker Background Check (Indicate # of checks performed 59)			1,420
Patient Background Checks 300			3,000
Dues & Subscriptions			494
Licenses, Inspections & Permits			1,665
Extended Care Consulting Allocation			2,644
Extended Care Clinical Allocation			126
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 9,725
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			1,160
Allocated from EC Consulting			146
Allocated from EC Clinical			1,557
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 2,863

*** Attach copy of IMRF notifications**
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A

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

(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 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,667 Line 10

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

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 233,432
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Yes Has any meal income been offset against related costs? Indicate the amount. \$ 12,296

(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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
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 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT