

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0047738 Facility Name: Beecher Manor Nrsg & Reh Ctr Address: 1201 Dixie Highway Beecher 60401 Number City Zip Code County: Will Telephone Number: (708)946-2600 Fax #: (708)946-9411 HFS ID Number: Date of Initial License for Current Owners: 2/1/2006 Type of Ownership: ☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: Steven N. Lavenda Telephone Number: (847) 282-6300

Email Address:

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr

0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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>47,580</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>47,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,135</u>	<u>4,550</u>	<u>13,820</u>	<u>38,505</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>20,135</u>	<u>4,550</u>	<u>13,820</u>	<u>38,505</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.93%

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 8,720

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: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	350,802	84,033	28,024	462,859		462,859	7,723	470,582			1
2	Food Purchase		245,468		245,468		245,468	(8)	245,460			2
3	Housekeeping	196,886	45,517		242,403		242,403	890	243,293			3
4	Laundry		17,133	94,869	112,002		112,002		112,002			4
5	Heat and Other Utilities			115,602	115,602		115,602	1,231	116,833			5
6	Maintenance	126,100		191,693	317,793		317,793	6,932	324,725			6
7	Other (specify):*							5,382	5,382			7
8	TOTAL General Services	673,788	392,151	430,188	1,496,127		1,496,127	22,150	1,518,277			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	2,657,602	266,403	165,735	3,089,740		3,089,740	29,414	3,119,154			10
10a	Therapy	232,550		419	232,969		232,969		232,969			10a
11	Activities	148,357	19,691		168,048		168,048		168,048			11
12	Social Services	163,578			163,578		163,578	18,349	181,927			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	14,361			14,361		14,361	6,890	21,251			15
16	TOTAL Health Care and Programs	3,216,448	286,094	182,654	3,685,196		3,685,196	54,653	3,739,849			16
	C. General Administration											
17	Administrative	94,792			94,792		94,792	77,071	171,863			17
18	Directors Fees											18
19	Professional Services			542,321	542,321	(796)	541,525	(437,300)	104,225			19
20	Dues, Fees, Subscriptions & Promotions			70,472	70,472		70,472	(20,657)	49,815			20
21	Clerical & General Office Expenses	86,178	57,098	674,552	817,828		817,828	(483,558)	334,270			21
22	Employee Benefits & Payroll Taxes			688,872	688,872		688,872	(16,004)	672,868			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,737	1,737		1,737	695	2,432			24
25	Other Admin. Staff Transportation			5,751	5,751		5,751	810	6,561			25
26	Insurance-Prop.Liab.Malpractice			137,026	137,026		137,026	1,882	138,908			26
27	Other (specify):*							30,751	30,751			27
28	TOTAL General Administration	180,970	57,098	2,120,731	2,358,799	(796)	2,358,003	(846,310)	1,511,693			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,071,206	735,343	2,733,573	7,540,122	(796)	7,539,326	(769,507)	6,769,819			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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			55,455	55,455		55,455	194,246	249,701			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							320,164	320,164			32
33	Real Estate Taxes			184,970	184,970	796	185,766	3,622	189,388			33
34	Rent-Facility & Grounds			798,594	798,594		798,594	(798,000)	594			34
35	Rent-Equipment & Vehicles			1,148	1,148		1,148	766	1,914			35
36	Other (specify):*											36
37	TOTAL Ownership			1,040,167	1,040,167	796	1,040,963	(279,202)	761,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		410,546	1,073,113	1,483,659		1,483,659	(21,370)	1,462,289			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			251,139	251,139		251,139		251,139			42
43	Other (specify):*			56,970	56,970		56,970	(56,970)				43
44	TOTAL Special Cost Centers		410,546	1,381,222	1,791,768		1,791,768	(78,340)	1,713,428			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,071,206	1,145,889	5,154,962	10,372,057		10,372,057	(1,127,049)	9,245,008			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(97,788)	30		9
10	Interest and Other Investment Income	(156)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(286)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(573,044)	21		24
25	Fund Raising, Advertising and Promotional	(17,520)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(95,093)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (783,887)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(343,162)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (343,162)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,127,049)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Meals Income	\$ (34)	02	1
2	Other Income	(151)	21	2
3	Patient Clothing	(121)	10	3
4	Theft Loss	(3,603)	21	4
5	Collection Expense	(6,549)	21	5
6	Chambers of Commerce Dues	(150)	20	6
7	PAC Dues	(4,368)	20	7
8	Lobbying	(875)	21	8
9	Annual Report	(250)	20	9
10	Building Company - Management Fee	(6,350)	21	10
11	Building Company - Filing Fee	(286)	21	11
12	Building Company - Amortization Expense	(4,841)	31	12
13	Non - Allowable Legal	(7,920)	19	13
14	Non - Allowable Expense	(56,970)	43	14
15	Capitalized R&M	(2,625)	06	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	(95,093)		49

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			145		7,578							7,723	1
2	Food Purchase	(320)		312									(8)	2
3	Housekeeping			803		87							890	3
4	Laundry													4
5	Heat and Other Utilities			1,120		111							1,231	5
6	Maintenance	(2,625)		2,340	7,012	205							6,932	6
7	Other (specify):*				4,335	1,047							5,382	7
8	TOTAL General Services	(2,945)		4,720	11,347	9,028							22,150	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(121)				31,526	(1,798)		(193)				29,414	10
10a	Therapy													10a
11	Activities													11
12	Social Services					18,349							18,349	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,890							6,890	15
16	TOTAL Health Care and Programs	(121)				56,765	(1,798)		(193)				54,653	16
	C. General Administration													
17	Administrative			2,342	13,335	61,394							77,071	17
18	Directors Fees													18
19	Professional Services	(7,920)		(321,291)		(108,089)							(437,300)	19
20	Fees, Subscriptions & Promotions	(22,288)		760		871							(20,657)	20
21	Clerical & General Office Expenses	(590,858)	6,636	4,719	80,806	15,139							(483,558)	21
22	Employee Benefits & Payroll Taxes				(16,004)								(16,004)	22
23	Inservice Training & Education													23
24	Travel and Seminar			119		576							695	24
25	Other Admin. Staff Transportation			810									810	25
26	Insurance-Prop.Liab.Malpractice			1,402		480							1,882	26
27	Other (specify):*				20,491	10,260							30,751	27
28	TOTAL General Administration	(621,066)	6,636	(311,139)	98,628	(19,369)							(846,310)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(624,132)	6,636	(306,419)	109,975	46,424	(1,798)		(193)				(769,507)	29

Summary B

Facility Name & ID Number	Beecher Manor Nrsg & Reh Ctr	#	0047738	Report Period Beginning:	01/01/16	Ending:	12/31/16
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(97,788)	289,601	1,869		564							194,246	30
31	Amortization of Pre-Op. & Org.	(4,841)	4,841											31
32	Interest	(156)	313,371	6,787		162							320,164	32
33	Real Estate Taxes			3,269		353							3,622	33
34	Rent-Facility & Grounds		(798,000)										(798,000)	34
35	Rent-Equipment & Vehicles			766									766	35
36	Other (specify):*													36
37	TOTAL Ownership	(102,785)	(190,187)	12,691		1,079							(279,202)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(21,370)						(21,370)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(56,970)											(56,970)	43
44	TOTAL Special Cost Centers	(56,970)					(21,370)						(78,340)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(783,887)	(183,551)	(293,728)	109,975	47,503	(23,168)		(193)				(1,127,049)	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	Rental Income	\$ 798,000	Beecher Properties, LLC	100.00%	\$	(798,000)	1
2	V	21	Management Fee		Beecher Properties, LLC	100.00%	6,350	6,350	2
3	V	21	Filing Fee		Beecher Properties, LLC	100.00%	286	286	3
4	V	30	Depreciation Expense		Beecher Properties, LLC	100.00%	289,601	289,601	4
5	V	31	Amortization Expense		Beecher Properties, LLC	100.00%	4,841	4,841	5
6	V	32	Interest Expense		Beecher Properties, LLC	100.00%	313,371	313,371	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 798,000			\$ 614,449	\$ * (183,551)	14

* 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.

☒ 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%	\$ 145	\$ 145	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	312	312	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	803	803	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,120	1,120	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,340	2,340	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,342	2,342	20
21	V	19	Professional Fees	325,968	Extended Care Consulting, LLC	100.00%	4,677	(321,291)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	760	760	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	4,719	4,719	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	119	119	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	810	810	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,402	1,402	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,869	1,869	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	6,787	6,787	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,269	3,269	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	766	766	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			\$ 325,968			\$ 32,240	\$ * (293,728)	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. ☒ 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%	7,012	\$ 7,012	15
16	V	06	Maintenance (Direct)	28,121	Extended Care Consulting, LLC	100.00%	28,121		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	657	657	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	3,678	3,678	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	13,335	13,335	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	80,806	80,806	22
23	V	21	Office and Clerical (Direct)	25,226	Extended Care Consulting, LLC	100.00%	25,226		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	17,218	17,218	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,273	3,273	25
26	V	22	Employee Benefits	16,004	Extended Care Consulting, LLC	100.00%		(16,004)	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			\$ 69,351			\$ 179,326	\$ * 109,975	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. ☒ 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%	\$ 87	\$ 87	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	111	111	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	205	205	17
18	V	19	Professional Fees	108,660	Extended Care Clinical, LLC	100.00%	571	(108,089)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	871	871	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,265	2,265	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	576	576	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	480	480	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	564	564	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	162	162	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	353	353	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	7,578	7,578	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,047	1,047	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	31,526	31,526	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	18,349	18,349	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,890	6,890	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	61,394	61,394	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	12,874	12,874	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	10,260	10,260	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 108,660			\$ 156,163	\$ * 47,503	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.

☒ 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	10	Nursing and Medical Records	\$ 24,966	MAC Rx, LLC	100.00%	\$ 23,168	\$ (1,798)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	296,715	MAC Rx, LLC	100.00%	275,345	(21,370)	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			\$ 321,682			\$ 298,514	\$ * (23,168)	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.

☒ 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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 262,922	\$ 262,922	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	262,922	CCS Employee Benefits Group	100.00%		(262,922)	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			\$ 262,922			\$ 262,922	\$ *	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	10	Various Equipment	3,320	Vent Lease LLC	100.00%	3,127	\$ (193)	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			\$ 3,320			\$ 3,127	\$ * (193)	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.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number

Beecher Manor Nrsg & Reh Ctr

0047738

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	B&Z GRANDCHILD TRUST	100.00%	BRIAR PLACE LTD.	INDIAN HEAD PARK	BEECHER PROPERTIES, LLC	EVANSTON	BUILDING CO.	1
2			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	Extended Care Consulting	Evanston	Mgmt / Bookkeeping	2
3			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	Extended Care Clinical	Evanston	Clinical	3
4			GRASMERE PLACE, LLC	CHICAGO	Care Centers Building	Evanston	Building Company	4
5			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	Vent Lease LLC	Evanston	Ventilator Equipment	5
6			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. Veba	Evanston	Health Insurance	6
7			MAJOR HOSPITAL DYER	DYER, IN	MAC RX	Des Plaines	Pharmacy	7
8			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	Reliable Medical Supply	Des Plaines	Medical Supplies	8
9			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				13
14			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			ST. JAMES WELLNESS REHAB VILLAS	CRETE				20
21			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				21
22			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				22
23			WHEATON CARE CENTER	WHEATON				23
24			SPRING CREEK	JOLIET				24
25			PARC OF JOLIET	JOLIET				25
26			ESTATES OF HYDE PARK	CHICAGO				26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Nrsgr & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,380,761	34	\$ 5,206	\$	38,505	\$ 145	1
2	02	Food	Patient Days	1,380,761	34	11,203		38,505	312	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		38,505	803	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		38,505	1,120	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		38,505	2,340	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		38,505	2,342	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		38,505	4,677	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		38,505	760	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		38,505	4,719	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		38,505	119	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		38,505	810	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		38,505	1,402	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		38,505	1,869	13
14	32	Interest	Patient Days	1,380,761	34	243,379		38,505	6,787	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		38,505	3,269	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		38,505	766	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,156,218	\$		\$ 32,240	25

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	06	Maintenance (Pooled)	Patient Days	1,380,761	34	251,431	251,431	38,505	7,012	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		28,121	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		38,505	657	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			3,678	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	38,505	13,335	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	38,505	80,806	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		25,226	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		38,505	17,218	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			3,273	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					\$ 5,222,483	\$ 4,461,323		\$ 179,326	25

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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	03	Housekeeping	Patient Days	818,091	19	\$ 1,844	\$	38,505	\$ 87	1
2	05	Utilities	Patient Days	818,091	19	2,355		38,505	111	2
3	06	Maintenance	Patient Days	818,091	19	4,352		38,505	205	3
4	19	Professional Fees	Patient Days	818,091	19	12,122		38,505	571	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512		38,505	871	5
6	21	Office & Clerical	Patient Days	818,091	19	48,124		38,505	2,265	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239		38,505	576	7
8	26	Insurance	Patient Days	818,091	19	10,196		38,505	480	8
9	30	Depreciation	Patient Days	818,091	19	11,978		38,505	564	9
10	32	Interest	Patient Days	818,091	19	3,446		38,505	162	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506		38,505	353	11
12	01	Dietary Salary	Patient Days	818,091	19	160,997	160,997	38,505	7,578	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		38,505	1,047	13
14	10	Nursing Salary	Patient Days	818,091	19	669,803	669,803	38,505	31,526	14
15	12	Social Service Salary	Patient Days	818,091	19	389,842	389,842	38,505	18,349	15
16	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		38,505	6,890	16
17	17	Administration Salary	Patient Days	818,091	19	1,304,395	1,304,395	38,505	61,394	17
18	21	Office Salary	Patient Days	818,091	19	273,525	273,525	38,505	12,874	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		38,505	10,260	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,317,844	\$ 2,798,561		\$ 156,163	25

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 MAC Rx, LLC
Street Address 2307 S. Mount Prospect Road
City / State / Zip Code Des Plaines, IL 60018
Phone Number (224)220-2700
Fax Number (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation			\$	\$		\$ 23,168	1
2	21	Clerical & General Office Expense	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						275,345	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					\$	\$		\$ 298,514	25

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 CCS Employee Benefits Group, Inc.
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847)905-4000
Fax Number (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 262,922	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					\$	\$		\$ 262,922	25

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 674-1180
Fax Number (847) 673-7741

	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	10	Various Equipment	Direct Allocation						3,127	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					\$	\$		\$ 3,127	25

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Nrsg & Reh Ctr # 0047738 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	CIB Bank		X				\$	6,464,290			\$	313,370	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	CIB Bank		X	Line of Credit				397,801					6
7	Allocated from Extended Care	X									6,787		7
8	Allocated from Extended Care	X			-						162		8
9	TOTAL Facility Related						\$	6,862,091			\$	320,319	9
	B. Non-Facility Related*												
10	Interest Income		X								(156)		10
11													11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	(156)	14
15	TOTALS (line 9+line14)						\$	6,862,091			\$	320,163	15

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.		\$	180,377		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.)		\$	181,840		2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,463		3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	187,129		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.)		\$	796		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.		\$	189,388		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	145,006	8	
		2012	157,126	9	
		2013	163,746	10	
		2014	171,788	11	
		2015	178,218	12	
2016 Accrual = \$178,218 x 1.05 = \$187,129					
Allocated - Extended Care Consuling - \$3,269					
Allocated - Extended Care Clinical - \$353					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$		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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beecher Manor Nrsg & Reh Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0047738

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 22-22-16-200-021-0000	Long Term Care Property	\$ 4,006.38	\$ 4,006.38
2. 22-22-16-200-028-0000	Long Term Care Property	\$ 174,211.30	\$ 174,211.30
3. See Attached	Alloc. From Care Centers Building, L	\$ 117,233.57	\$ 3,269.27
4. See Attached	Alloc. From Care Centers Building, L	\$ 117,233.57	\$ 353.29
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 412,684.82	\$ 181,840.24

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Beecher Manor Nrsg & Reh Ctr

COUNTY

Will

FACILITY IDPH LICENSE NUMBER

0047738

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

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

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	123,116	2006	\$ 163,718	1
2	Allocated - Care Centers Building			17,732	2
3	TOTALS	123,116		\$ 181,450	3

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	\$	39	\$ 65,297	\$ 65,297	\$ 710,104	4
5				2008	1,794,872		39	46,022	46,022	385,459	5
6				2009	3,618,157		39	93,675	93,675	736,120	6
7				2010	4,953		39	122	122	854	7
8						289,601			(289,601)		8
	Improvement Type**										
9	Various			2006	44,583		20	2,229	2,229	23,174	9
10	Various			2007	35,433		20	1,641	1,641	18,766	10
11	Various			2008	107,367		20	4,911	4,911	55,704	11
12	Various			2009	113,868		20	1,539	1,539	94,605	12
13	Various			2010	20,272		20	857	857	8,739	13
14	Various			2011	3,519		20			3,519	14
15	Various			2012	56,708		20	5,095	5,095	22,481	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr

0047738

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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)		84,184	1,172		1,172		56,722	68
69	Financial Statement Depreciation			55,455			(55,455)		69
70	TOTAL (lines 4 thru 69)		\$ 8,430,500	\$ 346,228		\$ 222,561	\$ (123,667)	\$ 2,116,247	70

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

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr

0047738

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,430,500	\$ 346,228		\$ 222,561	\$ (123,667)	\$ 2,116,247	1
2	Installation Of Drains, Vent And Sink In Dining Room	2013	8,500		20	850	850	3,258	2
3	Fence For Dumpster	2013	6,550		20	437	437	1,601	3
4	Cubicle Curtains	2013	16,444		20	1,644	1,644	5,755	4
5	Removed Trees, 2 Barns, 1 Corn Silo And Concrete Foundation	2013	23,200		20	1,160	1,160	3,867	5
6	Roof Work	2014	5,300		20	265	265	751	6
7	Installed New Relay For Compressor	2014	2,980		20	149	149	348	7
8	South Corridor Hvac	2015	29,612		20	1,481	1,481	2,468	8
9	Replace Faulty Sprinkler Valve	2015	3,710		20	186	186	278	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,526,796	\$ 346,228		\$ 228,732	\$ (117,496)	\$ 2,134,573	34

**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		\$ 8,526,796	\$ 346,228		\$ 228,732	\$ (117,496)	\$ 2,134,573	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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,526,796	\$ 346,228		\$ 228,732	\$ (117,496)	\$ 2,134,573	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,526,796	\$ 346,228		\$ 228,732	\$ (117,496)	\$ 2,134,573	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,526,796	\$ 346,228		\$ 228,732	\$ (117,496)	\$ 2,134,573	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,526,796	\$ 346,228		\$ 228,732	\$ (117,496)	\$ 2,134,573	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,526,796	\$ 346,228		\$ 228,732	\$ (117,496)	\$ 2,134,573	34

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

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr

0047738

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

**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 12F, Carried Forward		\$	\$		\$	\$	\$	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
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr

0047738

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated - Extended Care Consulting	2002	22,053	565	35	565		8,081	3
4	Allocated - Extended Care Clinical	2002	2,383	61	35	61		873	4
5	Allocated - Extended Care Consulting Dyer Building	2007	6,693	148	35	148		1,408	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - Extended Care Consulting, LLC	2002	18,217		20			18,217	9
10	Allocated - Extended Care Consulting, LLC	2003	21,469		20			21,469	10
11	Allocated - Extended Care Consulting, LLC	2005	1,067	2	20	2		1,067	11
12	Allocated - Extended Care Consulting, LLC	2007	128	6	20	6		64	12
13	Allocated - Extended Care Consulting, LLC	2009	77	4	20	4		31	13
14	Allocated - Extended Care Consulting, LLC	2009	192	10	20	10		77	14
15	Allocated - Extended Care Consulting, LLC	2010	752	38	20	38		263	15
16	Allocated - Extended Care Consulting, LLC	2011	271	14	20	14		81	16
17	Allocated - Extended Care Consulting, LLC	2012	89	4	20	4		22	17
18	Allocated - Extended Care Consulting, LLC	2014	1,237	62	20	62		186	18
19	Allocated - Extended Care Consulting, LLC	2014	1,790	90	20	90		269	19
20	Allocated - Extended Care Consulting, LLC	2015	303	15	20	15		30	20
21	Allocated - Extended Care Consulting, LLC	2016	1,199	60	20	60		60	21
22	Allocated - Extended Care Consulting, LLC	2016	1,483	74	20	74		74	22
23									23
24	Allocated - Extended Care Clinical	2002	1,969		20			1,969	24
25	Allocated - Extended Care Clinical	2003	2,320		20			2,320	25
26	Allocated - Extended Care Clinical	2005	115		20			115	26
27	Allocated - Extended Care Clinical	2009	21	1	20	1		8	27
28	Allocated - Extended Care Clinical	2014	193	10	20	10		29	28
29	Allocated - Extended Care Clinical	2015	33	2	20	2		3	29
30	Allocated - Extended Care Clinical	2016	130	6	20	6		6	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 84,184	\$ 1,172		\$ 1,172	\$	\$ 56,722	34

**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 12H, Carried Forward		\$ 84,184	\$ 1,172		\$ 1,172	\$	\$ 56,722	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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 84,184	\$ 1,172		\$ 1,172	\$	\$ 56,722	34

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

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	\$136,763	\$636	\$19,885	\$19,249	10	\$77,743	71
72	Current Year Purchases	6,555		460	460	10	460	72
73	Fully Depreciated Assets	685,620				10	685,620	73
74								74
75	TOTALS	\$828,938	\$636	\$20,344	\$19,708		\$763,823	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		Alloc. - Extended Care Consultin	2016	\$5,033	\$142	\$142		5	\$4,748	76
77		Alloc. - Extended Care Clinical	2016	2,418	484	484		5	2,166	77
78										78
79										79
80	TOTALS			\$7,451	\$626	\$626			\$6,914	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$9,544,635	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$347,490	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$249,702	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(97,788)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,905,310	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	CIP	\$337,149	92
93			93
94			94
95		\$337,149	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?

☐ 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	Storage Rental				594			5
6								6
7	TOTAL				\$ 594			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: \$ 1,914

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. /2017	\$
13. /2018	\$
14. /2019	\$

* 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

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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

HFS 3745 (N-4-99)

IL478-2471

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	\$		\$ 486,030	\$		\$ 486,030	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			105,267			105,267	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			481,555			481,555	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				296,716		296,716	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					261	113,830		114,091	13
14	TOTAL			\$		\$ 1,073,113	\$ 410,546		\$ 1,483,659	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 641,631	\$ 661,361	1
2	Cash-Patient Deposits	17,316	17,316	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,947,296	1,947,296	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,261	41,261	6
7	Other Prepaid Expenses	8,602	8,602	7
8	Accounts Receivable (owners or related parties)	2,671,236	2,180,708	8
9	Other(specify): <u>See Attached Schedule</u>	44,032	44,032	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,371,374	\$ 4,900,576	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	434,398	434,398	15
16	Equipment, at Historical Cost	367,265	798,963	16
17	Accumulated Depreciation (book methods)	(605,936)	(3,338,941)	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): <u>See Attached Schedule</u>	3,509	380,340	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 199,236	\$ 6,403,044	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,570,610	\$ 11,303,620	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 815,198	\$ 815,197	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,110	14,110	28
29	Short-Term Notes Payable	397,801	397,801	29
30	Accrued Salaries Payable	158,636	158,636	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,951	6,951	31
32	Accrued Real Estate Taxes(Sch.IX-B)	187,129	187,129	32
33	Accrued Interest Payable		13,360	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	2,520	2,520	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,582,345	\$ 1,595,704	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,464,290	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,464,290	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,582,345	\$ 8,059,994	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,988,265	\$ 3,243,626	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,570,610	\$ 11,303,620	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,572,402	1
2	Restatements (describe):		2
3	Repairs & Maintenance	(1,947)	3
4	Rounding	(4)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,570,451	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	744,844	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	(327,030)	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)	\$ 417,814	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,988,265	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr

0047738

Report Period Beginning: 01/01/16

Ending:

12/31/16

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,948,820	1
2	Discounts and Allowances for all Levels	(4,807,022)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,141,798	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,472,407	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,472,407	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	1,889	13
14	Non-Patient Meals	34	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	304,438	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	66,646	19
20	Radiology and X-Ray	82,518	20
21	Other Medical Services	46,864	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 502,389	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	156	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 156	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	151	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 151	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,116,901	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,496,127	31
32	Health Care	3,685,196	32
33	General Administration	2,358,799	33
	B. Capital Expense		
34	Ownership	1,040,167	34
	C. Ancillary Expense		
35	Special Cost Centers	1,540,629	35
36	Provider Participation Fee	251,139	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,372,057	40
41	Income before Income Taxes (line 30 minus line 40)**	744,844	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 744,844	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,559,996	44
45	Private Pay - Net Inpatient Revenue	1,599,537	45
46	Medicare - Net Inpatient Revenue	596,296	46
47	Other-(specify) <u>Hospice</u>	417,984	47
48	Other-(specify) <u>Insurance</u>	(32,015)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,141,798	49

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,858	2,156	\$ 107,254	\$ 49.75	1
2	Assistant Director of Nursing	1,876	2,275	89,773	39.46	2
3	Registered Nurses	22,235	24,316	793,046	32.61	3
4	Licensed Practical Nurses	23,315	26,004	734,315	28.24	4
5	CNAs & Orderlies	62,953	68,253	893,303	13.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,525	10,662	232,550	21.81	8
9	Activity Director	1,870	2,051	55,647	27.13	9
10	Activity Assistants	8,201	8,696	92,710	10.66	10
11	Social Service Workers	7,406	8,007	163,578	20.43	11
12	Dietician					12
13	Food Service Supervisor	3,385	3,667	97,625	26.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,709	7,232	89,781	12.41	15
16	Dishwashers	16,889	18,549	163,396	8.81	16
17	Maintenance Workers	6,198	6,936	126,100	18.18	17
18	Housekeepers	17,793	18,704	196,886	10.53	18
19	Laundry					19
20	Administrator	1,930	2,117	94,792	44.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,227	6,831	86,178	12.62	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	1,735	1,943	36,094	18.58	31
32	Other Health Care(specify)					32
33	Other(specify)	1,601	1,642	18,179	11.07	33
34	TOTAL (lines 1 - 33)	201,706	220,041	\$ 4,071,207 *	\$ 18.50	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	542	\$ 28,024	01-03	35
36	Medical Director	Monthly	16,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,282	10-03	39
40	Physical Therapy Consultant	8	419	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	550	\$ 53,225		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	6,349	157,453	10-03	52
53	TOTAL (lines 50 - 52)	6,349	\$ 157,453		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Beecher Manor Nrsg & Reh Ctr

#

0047738

Report Period Beginning:

01/01/16

Ending:

12/31/16

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
Michael Stoudt		Administrator	0	\$ 94,792	Workers' Compensation Insurance		\$ 162,358	IDPH License Fee		\$ 1,990		
					Unemployment Compensation Insurance		60,270	Advertising: Employee Recruitment		24,032		
					FICA Taxes		295,443	Health Care Worker Background Check		3,651		
					Employee Health Insurance		144,440	(Indicate # of checks performed 324)				
					Employee Meals			Patient Background Checks				
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		15,253		
					Employee Physicals		417	Licenses & Permits		3,258		
					Other Employee Welfare		6,382	Allocated - Extended Care Consulting		760		
					Holiday Expense		3,558	Allocated - Extended Care Clinical		871		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 94,792	TOTAL (agree to Schedule V, line 22, col.8)				\$ 672,868	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 49,815
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount		Description		Line #	Amount	Description		Amount	
			\$					\$	Out-of-State Travel		\$	
									In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$								
C. Professional Services												
Vendor/Payee		Type	Amount									
Marcum LLP		Accounting	\$ 24,650						Seminar Expense		1,737	
Personal Planners		Unemployment Tax Cons.	1,101						Allocated - Extended Care Consulting		119	
Pinnacle Quality Insight		Customer Satisfaction	2,744						Allocated - Extended Care Clinical		576	
Blymas		Tax Credit Services	2,702									
Advanced Discovery Inc		Data Management	164						Entertainment Expense		()	
See Attached		Legal	48,001						(agree to Sch. V, line 24, col. 8)			
ECC Clinical		Home Office Expense	108,660						TOTAL		\$ 2,432	
ECC Consulting		Home Office Expense	325,968									
Paycor		Payroll Services	24,952									
National Datacare Corporation		Resident Fund Processing	540									
Ability Network		Medicare Billing	1,911									
See Supplemental Schedule			928									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 542,321	TOTAL				\$			

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Beecher Manor Nrsg & Reh Ctr	STATE OF ILLINOIS # 0047738	Report Period Beginning: 01/01/16	Ending: 12/31/16
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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$13,236

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 81,293 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. _____

(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. \$ 251,139
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 benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 34

(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? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees