

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0047738

**Facility Name:** Beecher Manor Nrsg & Rehab 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:** 203583195-001

**Date of Initial License for Current Owners:** 02/01/07

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 2/1/2006 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

MAIL TO: BUREAU OF HEALTH FINANCE  
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr# 0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

## 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 \_\_\_\_\_

	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>96</u>	Skilled (SNF)	<u>96</u>	<u>32,064</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>96</u>	TOTALS	<u>96</u>	<u>32,064</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,736</u>	<u>7,359</u>	<u>4,560</u>	<u>28,655</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>16,736</u>	<u>7,359</u>	<u>4,560</u>	<u>28,655</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.37%

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)

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

G. Do pages 3 &amp; 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 2/1/06

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 2/1/06 NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 96 and days of care provided 4,490Medicare Intermediary National Government Services

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr # 0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

**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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	178,951	32,479	5,164	216,594		216,594	2,125	218,719			1
2	Food Purchase		167,225		167,225		167,225	(2,386)	164,839			2
3	Housekeeping	59,551	22,585		82,136		82,136	(1,559)	80,577			3
4	Laundry	5,785	4,517	70,645	80,947		80,947	(46)	80,901			4
5	Heat and Other Utilities			69,686	69,686		69,686	1,160	70,846			5
6	Maintenance	99,377	53	41,381	140,811		140,811	4,607	145,418			6
7	Other (specify):*							1,110	1,110			7
8	<b>TOTAL General Services</b>	<b>343,664</b>	<b>226,859</b>	<b>186,876</b>	<b>757,399</b>		<b>757,399</b>	<b>5,011</b>	<b>762,410</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			12,650	12,650		12,650		12,650			9
10	Nursing and Medical Records	1,555,259	79,859	63,212	1,698,330		1,698,330	5,353	1,703,683			10
10a	Therapy	79,680		1,548	81,228		81,228	131,710	212,938			10a
11	Activities	83,404	4,762	196	88,362		88,362		88,362			11
12	Social Services	64,915		972	65,887		65,887	6,445	72,332			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							19,820	19,820			15
16	<b>TOTAL Health Care and Programs</b>	<b>1,783,258</b>	<b>84,621</b>	<b>78,578</b>	<b>1,946,457</b>		<b>1,946,457</b>	<b>163,328</b>	<b>2,109,785</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	73,828			73,828		73,828	25,953	99,781			17
18	Directors Fees											18
19	Professional Services			243,179	243,179		243,179	(201,971)	41,208			19
20	Dues, Fees, Subscriptions & Promotions			30,443	30,443		30,443	(3,830)	26,613			20
21	Clerical & General Office Expenses	95,154	24,391	152,974	272,519		272,519	(59,237)	213,282			21
22	Employee Benefits & Payroll Taxes			387,290	387,290		387,290	(4,670)	382,620			22
23	Inservice Training & Education			197	197		197		197			23
24	Travel and Seminar			1,095	1,095		1,095	2,171	3,266			24
25	Other Admin. Staff Transportation			3,920	3,920		3,920	5	3,925			25
26	Insurance-Prop.Liab.Malpractice			79,556	79,556		79,556	490	80,046			26
27	Other (specify):*							14,303	14,303			27
28	<b>TOTAL General Administration</b>	<b>168,982</b>	<b>24,391</b>	<b>898,654</b>	<b>1,092,027</b>		<b>1,092,027</b>	<b>(226,786)</b>	<b>865,241</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,295,904</b>	<b>335,871</b>	<b>1,164,108</b>	<b>3,795,883</b>		<b>3,795,883</b>	<b>(58,447)</b>	<b>3,737,436</b>			<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr #0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			2,827	2,827	2,827	155,515	158,342				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,238	2,238	2,238	210,094	212,332				32
33	Real Estate Taxes			77,800	77,800	77,800	1,012	78,812				33
34	Rent-Facility & Grounds			264,000	264,000	264,000	(261,980)	2,020				34
35	Rent-Equipment & Vehicles			3,055	3,055	3,055	1,036	4,091				35
36	Other (specify):*						1,507	1,507				36
37	<b>TOTAL Ownership</b>			349,920	349,920	349,920	107,184	457,104				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		197,564	326,563	524,127	524,127	(2,953)	521,174				39
40	Barber and Beauty Shops			1,760	1,760	1,760	(1,760)					40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,096	48,096	48,096		48,096				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		197,564	376,419	573,983	573,983	(4,713)	569,270				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,295,904	533,435	1,890,447	4,719,786	4,719,786	44,024	4,763,810				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending: 12/31/06

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(888)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,624	30		9
10	Interest and Other Investment Income	(2,747)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(429)	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	(108,945)	21		24
25	Fund Raising, Advertising and Promotional	(8,634)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(143)	20		28
29	Other-Attach Schedule	(49,782)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (165,944)		\$	30

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	2	
		Amount	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)	209,968		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 209,968		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 44,024		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1		40
2		21
3		21
4		10
5		21
6		21
7		19
8		19
9		21
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97		97
98		98
99		99
100		100
101	(49,752)	101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Beecher Manor Nrsg &amp; Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary			242		(141)		1,981	43				2,125	1
2	Food Purchase	(1,317)							(1,069)				(2,386)	2
3	Housekeeping					(1,559)							(1,559)	3
4	Laundry					(46)							(46)	4
5	Heat and Other Utilities			1,106			49		5				1,160	5
6	Maintenance			1,678	2,867	(43)	33		8	64			4,607	6
7	Other (specify):*				771			339					1,110	7
8	<b>TOTAL General Services</b>	<b>(1,317)</b>		<b>3,026</b>	<b>3,638</b>	<b>(1,789)</b>	<b>82</b>	<b>2,320</b>	<b>(1,013)</b>	<b>64</b>			<b>5,011</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(53)				(5,206)		10,612					5,353	10
10a	Therapy							1,317			130,393		131,710	10a
11	Activities													11
12	Social Services				1,583			4,862					6,445	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				212			2,363			17,245		19,820	15
16	<b>TOTAL Health Care and Programs</b>	<b>(53)</b>			<b>1,795</b>	<b>(5,206)</b>		<b>19,154</b>			<b>147,638</b>		<b>163,328</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			1,080	2,396			18,069	74		4,334		25,953	17
18	Directors Fees													18
19	Professional Services	(17,225)		(139,272)			(45,624)		2		148		(201,971)	19
20	Fees, Subscriptions & Promotions	(8,777)		2,973			20		3		1,951		(3,830)	20
21	Clerical & General Office Expenses	(139,689)	276	6,211	68,103		15	5,093	101		653		(59,237)	21
22	Employee Benefits & Payroll Taxes				(369)	(128)						(4,173)	(4,670)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,876			22				273		2,171	24
25	Other Admin. Staff Transportation								5				5	25
26	Insurance-Prop.Liab.Malpractice			(267)			11		7		739		490	26
27	Other (specify):*				10,514			3,155	25		609		14,303	27
28	<b>TOTAL General Administration</b>	<b>(165,691)</b>	<b>276</b>	<b>(127,399)</b>	<b>80,644</b>	<b>(128)</b>	<b>(45,556)</b>	<b>26,317</b>	<b>217</b>		<b>8,707</b>	<b>(4,173)</b>	<b>(226,786)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(167,061)</b>	<b>276</b>	<b>(124,373)</b>	<b>86,077</b>	<b>(7,123)</b>	<b>(45,474)</b>	<b>47,791</b>	<b>(796)</b>	<b>64</b>	<b>156,345</b>	<b>(4,173)</b>	<b>(58,447)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr # 0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	5,624	143,561	5,338			147		2	843			155,515	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,747)	197,763	12,519			420			91	2,048		210,094	32
33	Real Estate Taxes			914			96		2				1,012	33
34	Rent-Facility & Grounds		(264,000)	2,020									(261,980)	34
35	Rent-Equipment & Vehicles			541					3		492		1,036	35
36	Other (specify):*		1,507										1,507	36
37	<b>TOTAL Ownership</b>	<b>2,877</b>	<b>78,831</b>	<b>21,332</b>			<b>663</b>		<b>7</b>	<b>934</b>	<b>2,540</b>		<b>107,184</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(1,552)			429	(1,830)			(2,953)	39
40	Barber and Beauty Shops	(1,760)											(1,760)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,760)</b>				<b>(1,552)</b>			<b>429</b>	<b>(1,830)</b>			<b>(4,713)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(165,944)</b>	<b>79,107</b>	<b>(103,041)</b>	<b>86,077</b>	<b>(8,675)</b>	<b>(44,811)</b>	<b>47,791</b>	<b>(360)</b>	<b>(832)</b>	<b>158,885</b>	<b>(4,173)</b>	<b>44,024</b>	<b>45</b>

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rothner Family Grandchildren Trust	100%	See Attached		See Attached		
				Beecher Properties LLC		Building Co.

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 264,000	Beecher Properties LLC		\$	\$ (264,000)	1
2	V	33 Real Estate Tax	77,800			77,800		2
3	V	21 Misc. Fees				276	276	3
4	V	36 Amortization				1,507	1,507	4
5	V	32 Interest				197,763	197,763	5
6	V	30 Depreciation				143,561	143,561	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 341,800			\$ 420,907	\$ * 79,107	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr # 0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

## 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	\$	Care Centers, Inc.	100.00%	\$ 242	242	15
16	V	05 Utilities		Care Centers, Inc.	100.00%	1,106	1,106	16
17	V	06 Maintenance		Care Centers, Inc.	100.00%	1,678	1,678	17
18	V							18
19	V	17 Administration		Care Centers, Inc.	100.00%	1,080	1,080	19
20	V	19 Professional Fees	147,465	Care Centers, Inc.	100.00%	8,193	(139,272)	20
21	V	20 Dues and Subscriptions		Care Centers, Inc.	100.00%	2,973	2,973	21
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	6,211	6,211	22
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	1,876	1,876	23
24	V	26 Insurance		Care Centers, Inc.	100.00%	(267)	(267)	24
25	V	30 Depreciation		Care Centers, Inc.	100.00%	5,338	5,338	25
26	V	32 Interest		Care Centers, Inc.	100.00%	12,519	12,519	26
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	914	914	27
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	2,020	2,020	28
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	541	541	29
30	V	25 Bus Reimbursement		Care Centers, Inc.	100.00%			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		\$ 147,465			\$ 44,424	\$ * (103,041)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr # 0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

## 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 Salary		Care Centers, Inc.	100.00%	2,867	2,867	15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	415	415	16
17	V	10 Nursing Salary		Care Centers, Inc.	100.00%			17
18	V	10a Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	12 Social Service Salary		Care Centers, Inc.	100.00%	1,583	1,583	19
20	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	212	212	20
21	V	17 Administration Salary		Care Centers, Inc.	100.00%	2,396	2,396	21
22	V	21 Office Salary		Care Centers, Inc.	100.00%	68,103	68,103	22
23	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	10,514	10,514	23
24	V							24
25	V							25
26	V	06 Maintenance Salary	3,235	Care Centers, Inc.	100.00%	3,235		26
27	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	356	356	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V	17 Administration Salary		Care Centers, Inc.	100.00%			32
33	V	21 Office Salary		Care Centers, Inc.	100.00%			33
34	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%			34
35	V							35
36	V	22 Employee Benefits	369				(369)	36
37	V							37
38	V							38
39	Total		\$ 3,604			\$ 89,681	\$ * 86,077	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$ 1,738	Xcel Supply, LLC	100.00%	\$ 1,597	(141)	15
16	V	03 Housekeeping	19,221	Xcel Supply, LLC	100.00%	17,662	(1,559)	16
17	V	04 Laundry	564	Xcel Supply, LLC	100.00%	519	(46)	17
18	V	06 Repairs & Maintenance	536	Xcel Supply, LLC	100.00%	492	(43)	18
19	V	10 Nursing	64,193	Xcel Supply, LLC	100.00%	58,987	(5,206)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions		Xcel Supply, LLC	100.00%			22
23	V	21 Clerical & General Office		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	1,584	Xcel Supply, LLC	100.00%	1,455	(128)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	19,138	Xcel Supply, LLC	100.00%	17,586	(1,552)	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		\$ 106,974			\$ 98,299	\$ * (8,675)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr # 0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

## VII. RELATED PARTIES (continued)

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

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

1		2		3 Cost Per General Ledger		4		5 Cost to Related Organization		6		7		8 Difference:	
Schedule V		Line		Item		Amount		Name of Related Organization		Percent of Ownership		Operating Cost of Related Organization		Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	\$	45,837			Care Centers Clinical, Inc.	100.00%	\$	213	\$	(45,624)		15
16	V	20	Dues and Subscriptions					Care Centers Clinical, Inc.	100.00%		20		20		16
17	V	21	Office and Clerical					Care Centers Clinical, Inc.	100.00%		15		15		17
18	V	24	Travel and Seminar					Care Centers Clinical, Inc.	100.00%		22		22		18
19	V	30	Depreciation					Care Centers Clinical, Inc.	100.00%		147		147		19
20	V	32	Interest					Care Centers Clinical, Inc.	100.00%		420		420		20
21	V	05	Utilities					Care Centers Clinical, Inc.	100.00%		49		49		21
22	V	06	Maintenance					Care Centers Clinical, Inc.	100.00%		33		33		22
23	V	26	Insurance					Care Centers Clinical, Inc.	100.00%		11		11		23
24	V	33	Real Estate Taxes					Care Centers Clinical, Inc.	100.00%		96		96		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			\$	45,837					\$	1,026	\$ *	(44,811)		39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01	Dietary Salary	\$	Care Centers Clinical, Inc.	100.00%	\$ 1,981	\$ 1,981	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	339	339	16
17	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	10,612	10,612	17
18	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	1,317	1,317	18
19	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	4,862	4,862	19
20	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	2,363	2,363	20
21	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	18,069	18,069	21
22	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	5,093	5,093	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	3,155	3,155	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		\$				\$ 47,791	\$ * 47,791	39

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

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr # 0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers Health Systems	100.00%	\$ 43	\$ 43	15	
16	V	02	Food	1,118	Care Centers Health Systems	100.00%	49	(1,069)	16	
17	V	05	Utilities		Care Centers Health Systems	100.00%	5	5	17	
18	V	06	Maintenance		Care Centers Health Systems	100.00%	8	8	18	
19	V	17	Administration		Care Centers Health Systems	100.00%	11	11	19	
20	V	19	Professional Fees		Care Centers Health Systems	100.00%	2	2	20	
21	V	20	Dues & Subscriptions		Care Centers Health Systems	100.00%	3	3	21	
22	V	21	Office & Clerical		Care Centers Health Systems	100.00%	7	7	22	
23	V	25	Auto Expenses		Care Centers Health Systems	100.00%	5	5	23	
24	V	26	Insurance		Care Centers Health Systems	100.00%	7	7	24	
25	V	30	Depreciation		Care Centers Health Systems	100.00%	2	2	25	
26	V	32	Interest Expense		Care Centers Health Systems	100.00%			26	
27	V	33	Real Estate Taxes		Care Centers Health Systems	100.00%	2	2	27	
28	V	35	Rent - Equipment & Auto		Care Centers Health Systems	100.00%	3	3	28	
29	V	39	Ancillary Enteral Supplies	34	Care Centers Health Systems	100.00%	463	429	29	
30	V	17	Administrative-Salary		Care Centers Health Systems	100.00%	63	63	30	
31	V	21	Office & Clerical-Salary		Care Centers Health Systems	100.00%	94	94	31	
32	V	27	Emp. Ben. - Gen. Admin.		Care Centers Health Systems	100.00%	25	25	32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 1,152			\$ 792	\$ *	(360)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 64	\$ 64	15
16	V	30	Depreciation		Vent Lease, LLC.	100.00%	843	843	16
17	V	32	Interest		Vent Lease, LLC.	100.00%	91	91	17
18	V	39	Vent/Ancillary Reimbursement	1,830	Vent Lease, LLC.	100.00%		(1,830)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,830			\$ 998	\$ * (832)	39

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

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr# 0047738Report Period Beginning: 2/1/2006Ending: 12/31/06

## 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	10A THERAPY	\$	THERAPY WORKS REHAB. SERVICES, LLC	100.00%	\$ 130,393	\$ 130,393	15
16	V	15 HEALTHCARE EMP. BEN.				17,245	17,245	16
17	V	17 ADMINISTRATIVE				4,334	4,334	17
18	V	19 PROFESSIONAL FEES				148	148	18
19	V	20 DUES, FEES, SUBS				1,951	1,951	19
20	V	21 CLERICAL AND GENERAL				653	653	20
21	V	24 SEMINARS				273	273	21
22	V	26 INSURANCE				739	739	22
23	V	27 GEN ADMIN.- EMP. BEN.				609	609	23
24	V	32 INTEREST EXPENSE				2,048	2,048	24
25	V	35 EQUIPMENT RENTAL				492	492	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		\$			\$ 158,885	\$ * 158,885	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 206,078	\$ 206,078	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	210,251	CCS EMPLOYEE BENEFIT GROUP	100.00%		(210,251)	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		\$ 210,251			\$ 206,078	\$ * (4,173)	39

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr # 0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

## 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	Eric Rothner	Relative	Administrative		See Attached	0.60	1.30%	Alloc Salary	\$ 983	17-7	1
2	Gale Rothner	Relative	Administrative		See Attached	0.63	1.80%	Alloc Salary	1,404	17-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	0.99	1.80%	Alloc Salary	2,404	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,791		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers, Inc.  
 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	1,592,658	31	\$ 13,468	\$ 28,665	\$ 242	1
2	05	Utilities	Patient Days	1,592,658	31	61,456	28,665	1,106	2
3	06	Maintenance	Patient Days	1,592,658	31	93,209	28,665	1,678	3
4									4
5	17	Administration	Patient Days	1,592,658	31	60,000	28,665	1,080	5
6	19	Professional Fees	Patient Days	1,592,658	31	455,203	28,665	8,193	6
7	20	Dues and Subscriptions	Patient Days	1,592,658	31	165,158	28,665	2,973	7
8	21	Office & Clerical	Patient Days	1,592,658	31	345,085	28,665	6,211	8
9	24	Travel and Seminar	Patient Days	1,592,658	31	104,250	28,665	1,876	9
10	26	Insurance	Patient Days	1,592,658	31	(14,814)	28,665	(267)	10
11	30	Depreciation	Patient Days	1,592,658	31	296,584	28,665	5,338	11
12	32	Interest	Patient Days	1,592,658	31	695,586	28,665	12,519	12
13	33	Real Estate Taxes	Patient Days	1,592,658	31	50,799	28,665	914	13
14	34	Rent - Building	Patient Days	1,592,658	31	112,256	28,665	2,020	14
15	35	Rent - Equipment & Auto	Patient Days	1,592,658	31	30,066	28,665	541	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,468,306	\$	\$ 44,424	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers, Inc.  
 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 Salary	Patient Days	1,592,658	31	159,318	159,318	28,665	2,867	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	31	23,038		28,665	415	2
3	10	Nursing Salary	Patient Days	1,592,658	31			28,665		3
4	10a	Rehab Salary	Patient Days	1,592,658	31			28,665		4
5	12	Social Service Salary	Patient Days	1,592,658	31	87,938	87,938	28,665	1,583	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	31	11,794		28,665	212	6
7	17	Administration Salary	Patient Days	1,592,658	31	133,122	133,122	28,665	2,396	7
8	21	Office Salary	Patient Days	1,592,658	31	3,783,895	3,783,895	28,665	68,103	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	31	584,195		28,665	10,514	9
10										10
11										11
12	06	Maintenance Salary	Direct Allocation		26	366,540	366,540		3,235	12
13	07	Emp. Ben. - Gen. Serv.	Direct Allocation		26	60,795			356	13
14										14
15										15
16										16
17										17
18										18
19	21	Office Salary	Direct Allocation		23	418,249	418,249			19
20	27	Emp. Ben. - Gen. Admin.	Direct Allocation		23	70,744				20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,699,628	\$ 4,949,062		\$ 89,681	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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			\$	\$		\$ 1,597	1
2	03	Housekeeping						17,662	2
3	04	Laundry						519	3
4	06	Repairs & Maintenance						492	4
5	10	Nursing						58,987	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees, Subscriptions & Prom							8
9	21	Clerical & General Office							9
10	22	Employee Benefits						1,455	10
11	24	Seminars & Education							11
12	39	Ancillary						17,586	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				\$	\$		\$ 98,299	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Clinical, Inc.  
 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	19	Professional Fees	Patient Days	1,592,658	30	\$ 11,820	\$ 28,665	\$ 213	1
2	20	Dues and Subscriptions	Patient Days	1,592,658	30	1,118	28,665	20	2
3	21	Office and Clerical	Patient Days	1,592,658	30	847	28,665	15	3
4	24	Travel and Seminar	Patient Days	1,592,658	30	1,201	28,665	22	4
5	30	Depreciation	Patient Days	1,592,658	30	8,167	28,665	147	5
6	32	Interest	Patient Days	1,592,658	30	23,321	28,665	420	6
7	05	Utilities	Patient Days	1,592,658	30	2,749	28,665	49	7
8	06	Maintenance	Patient Days	1,592,658	30	1,817	28,665	33	8
9	26	Insurance	Patient Days	1,592,658	30	623	28,665	11	9
10	33	Real Estate Taxes	Patient Days	1,592,658	30	5,358	28,665	96	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					\$ 57,020	\$	\$ 1,026	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	01	Dietary Salary	Patient Days	1,592,658	30	110,093	110,093	28,665	1,981	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	30	18,826	18,826	28,665	339	2
3	10	Nursing Salary	Patient Days	1,592,658	30	589,608		28,665	10,612	3
4	10a	Rehab Salary	Patient Days	1,592,658	30	73,158	73,158	28,665	1,317	4
5	12	Social Service Salary	Patient Days	1,592,658	30	270,126	270,126	28,665	4,862	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	30	131,280		28,665	2,363	6
7	17	Administration Salary	Patient Days	1,592,658	30	1,003,912		28,665	18,069	7
8	21	Office Salary	Patient Days	1,592,658	30	282,969	282,969	28,665	5,093	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	30	175,293		28,665	3,155	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					\$ 2,655,265	\$ 755,172		\$ 47,791	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Health Systems  
 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	Billable Income	2,455,454	33	91,698	1,152	43	1
2	02	Food	Billable Income	2,455,454	33	104,128	1,152	49	2
3	05	Utilities	Billable Income	2,455,454	33	10,245	1,152	5	3
4	06	Maintenance	Billable Income	2,455,454	33	16,367	1,152	8	4
5	17	Administration	Billable Income	2,455,454	33	24,000	1,152	11	5
6	19	Professional Fees	Billable Income	2,455,454	33	4,618	1,152	2	6
7	20	Dues & Subscriptions	Billable Income	2,455,454	33	7,167	1,152	3	7
8	21	Office & Clerical	Billable Income	2,455,454	33	15,126	1,152	7	8
9	25	Auto Expenses	Billable Income	2,455,454	33	10,605	1,152	5	9
10	26	Insurance	Billable Income	2,455,454	33	15,802	1,152	7	10
11	30	Depreciation	Billable Income	2,455,454	33	3,557	1,152	2	11
12	32	Interest Expense	Billable Income	2,455,454	33	392	1,152		12
13	33	Real Estate Taxes	Billable Income	2,455,454	33	3,660	1,152	2	13
14	35	Rent - Equipment & Auto	Billable Income	2,455,454	33	6,478	1,152	3	14
15	39	Ancillary Enteral Supplies	Billable Income	2,455,454	33	987,356	1,152	463	15
16	17	Administrative-Salary	Billable Income	2,455,454	33	134,802	1,152	63	16
17	21	Office & Clerical-Salary	Billable Income	2,455,454	33	200,852	200,852	94	17
18	27	Emp. Ben. - Gen. Admin.	Billable Income	2,455,454	33	52,885	52,885	25	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,689,738	\$ 253,738	\$ 792	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending: 12/31/06

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

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	Repairs	Direct Billing	868,537	31	\$ 30,521	\$ 1,830	\$ 64	1
2	30	Depreciation	Direct Billing	868,537	31	400,000	1,830	843	2
3	32	Interest	Direct Billing	868,537	31	43,063	1,830	91	3
4	39	Vent/Ancillary Reimbursement							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					\$ 473,584	\$	\$ 998	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending: 12/31/06

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

Name of Related Organization THERAPY WORKS REHAB. SERVICES, LLC  
 Street Address 2201 WEST MAIN STREET  
 City / State / Zip Code EVANSTON, ILLINOIS 60202  
 Phone Number ( 847) 922-0702  
 Fax Number ( 847) 905-4040

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

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	10A	THERAPY	THERAPY WORKS FEES	1,681,285	9	\$ 1,341,785	\$ 1,262,093	163,385	\$ 130,393	1
2	15	HEALTHCARE EMP. BEN.	THERAPY WORKS FEES	1,681,285	9	177,453	163,385	163,385	17,245	2
3	17	ADMINISTRATIVE	THERAPY WORKS FEES	1,681,285	9	44,598	44,598	163,385	4,334	3
4	19	PROFESSIONAL FEES	THERAPY WORKS FEES	1,681,285	9	1,524	163,385	163,385	148	4
5	20	DUES, FEES, SUBS	THERAPY WORKS FEES	1,681,285	9	20,074	163,385	163,385	1,951	5
6	21	CLERICAL AND GENERAL	THERAPY WORKS FEES	1,681,285	9	6,717	163,385	163,385	653	6
7	24	SEMINARS	THERAPY WORKS FEES	1,681,285	9	2,806	163,385	163,385	273	7
8	26	INSURANCE	THERAPY WORKS FEES	1,681,285	9	7,608	163,385	163,385	739	8
9	27	GEN ADMIN.- EMP. BEN.	THERAPY WORKS FEES	1,681,285	9	6,264	163,385	163,385	609	9
10	32	INTEREST EXPENSE	THERAPY WORKS FEES	1,681,285	9	21,079	163,385	163,385	2,048	10
11	35	EQUIPMENT RENTAL	THERAPY WORKS FEES	1,681,285	9	5,067	163,385	163,385	492	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,634,975	\$ 1,306,691		\$ 158,885	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending: 12/31/06

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, IL 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

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	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 206,078	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				\$	\$		\$ 206,078	25

SEE ACCOUNTANTS' COMPILATION REPORT

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	CIB Bank		X	Mortgage	\$19,151.67	2/1/06	\$ 2,520,000	\$ 2,468,227		6.6500	\$ 165,506	1								
2	Lake Forest Bank		X	Mortgage				627,980			32,257	2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	Central Illinois Bank		X	Line of Credit							2,238	6								
7	Allocation from Care Centers		X								12,939	7								
8	See Supplemental Schedule										2,139	8								
9	<b>TOTAL Facility Related</b>				\$19,151.67		\$ 2,520,000	\$ 3,096,207			\$ 215,079	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(2,747)	10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(2,747)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,520,000	\$ 3,096,207			\$ 212,332	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr # 0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1							\$	\$		\$	1									
2											2									
3											3									
4											4									
5											5									
6											6									
7	<b>TOTAL Long-Term</b>										7									
<b>Working Capital</b>																				
8	Allocation from Ventlease		X				\$	\$		\$	91									
9	Allocation from Therapy Works		X								2,048									
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Working Capital</b>										2,139									
<b>B. Non-Facility Related*</b>																				
15							\$	\$		\$	15									
16											16									
17											17									
18											18									
19											19									
20	<b>TOTAL Non-Facility Related</b>										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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	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.)			\$ 1,012	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 1,012	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 77,800	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 78,812	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
<u>The facility was a Not-for-Profit building prior to 2/1/06, and therefore did not pay real estate taxes.</u>				
<u>Allocation from Care Centers \$1012</u>				
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Beecher Manor Nrsng & Rehab Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0047738

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>116,388.47</u>	\$ <u>897.95</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>116,388.47</u>	\$ <u>897.95</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

**IMPORTANT NOTICE**

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

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

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

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

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Beecher Manor Nrsng & Rehab Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0047738

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 37,095 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	<u>Facility</u>	<u>123,116</u>	<u>2006</u>	<u>\$ 163,718</u>	1
2	<u>Allocation from Care Centers</u>			<u>6,327</u>	2
3	<b>TOTALS</b>	<b>123,116</b>		<b>\$ 170,045</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Beecher Manor Nrsg & Rehab Ctr**

# **0047738**

Report Period Beginning:

**2/1/2006**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

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

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

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

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		2,546,584	57,222		61,075	3,853	61,075	67
68		24,828	704		1,028	324	4,096	68
69			2,826			(2,826)		69
70		\$ 2,571,412	\$ 60,752		\$ 62,103	\$ 1,351	\$ 65,171	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 2,571,412	\$ 60,752		\$ 62,103	\$ 1,351	\$ 65,171	1
2	Doors	2006	4,300		20	197	197	197	2
3	Conduit Instalation	2006	4,485		20	206	206	206	3
4	Fire Rated Wall	2006	3,800		20	63	63	63	4
5	Facility Signs	2006	3,302		20	41	41	41	5
6	Electrical Outlets	2006	2,700		20	23	23	23	6
7	Fire Doors	2006	8,235		20	69	69	69	7
8	Cabinets	2006	14,800		20	247	247	247	8
9	Hvac Units	2006	2,961		20	37	37	37	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)		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054		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
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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)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (lines 1 thru 33)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	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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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)		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (lines 1 thru 33)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054		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)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-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		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
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25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054		1
2									2
3									3
4									4
5									5
6									6
7									7
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12J, Carried Forward	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12L, Carried Forward	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12O, Carried Forward	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	1	
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-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		\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,615,995	\$ 60,752		\$ 62,986	\$ 2,234	\$ 66,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	96		2006	1985	\$ 2,378,189	\$ 53,438	39	\$ 53,357	\$ (81)	\$ 53,357	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Site Improvements		2006		168,395	3,784	20	7,718	3,934	7,718	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$ 2,546,584	\$ 57,222		\$ 61,075	\$ 3,853	\$ 61,075	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocation - Care Center - 2201 Main LLC		2002	2002	\$ 7,873	\$ 202	39	\$ 202		\$ 866	4
5	Allocation - Care Center Clinical - 2201 Main		2002	2002	830	21	39	21		91	5
6	Allocation - Care Centers Health Systems		2002	2002	15		39			2	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Allocation - Care Centers - 2201 Main LLC			2002	6,504	271	20	325	54	1,463	9
10	Allocation - Care Centers - 2201 Main LLC			2003	7,664	146	20	383	237	1,341	10
11	Allocation - Care Centers - 2201 Main LLC			2005	381	17	20	19	2	29	11
12											12
13	Allocation - Care Center Clinical - 2201 Main			2002	686	29	20	34	5	154	13
14	Allocation - Care Center Clinical - 2201 Main			2003	808	15	20	40	25	141	14
15	Allocation - Care Center Clinical - 2201 Main			2005	40	2	20	2		3	15
16											16
17	Allocation - Care Centers Health Systems			2002	12	1	20	1		3	17
18	Allocation - Care Centers Health Systems			2003	14		20	1	1	3	18
19	Allocation - Care Centers Health Systems			2005	1		20				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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr

# 0047738

Report Period Beginning:

2/1/2006

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	<b>TOTAL (lines 4 thru 69)</b>	\$	24,828	\$	704	\$	1,028	\$	324	\$	4,096	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr # 0047738 Report Period Beginning: 2/1/2006 Ending: 12/31/06

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-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	\$ 52,152	\$ 5,390	\$ 10,576	\$ 5,186	10	\$ 42,488	71
72	Current Year Purchases	449,757	86,366	83,665	(2,701)	10	83,665	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 501,909	\$ 91,756	\$ 94,241	\$ 2,485		\$ 126,153	75

## D. Vehicle Depreciation (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 from Care Centers		\$ 12,943	\$ 157	\$ 1,062	\$ 905	5	\$ 9,259	76
77		Alloc from Care Centers Clinical		787	53	53		5	53	77
78										78
79										79
80	TOTALS			\$ 13,730	\$ 210	\$ 1,115	\$ 905		\$ 9,312	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)	\$ 3,301,679	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 152,718	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 158,342	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,624	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 201,519	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	CON Fees (2006)	\$ 6,000	92
93			93
94			94
95		\$ 6,000	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocation from Care Centers				2,020			6
7	TOTAL				\$ 2,020			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 4,091 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

\* 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	\$		\$ 135,187	\$		\$ 135,187	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			33,417			33,417	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			155,605			155,605	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 prescripts				145,882		145,882	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					2,354	51,682		54,036	13
14	<b>TOTAL</b>			\$		\$ 326,563	\$ 197,564		\$ 524,127	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsg & Rehab Ctr# 0047738Report Period Beginning: 2/1/2006

Ending:

12/31/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 500	\$ 8,287	1
2	Cash-Patient Deposits	32,106	32,106	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	898,164	898,164	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,683	12,683	6
7	Other Prepaid Expenses	4,968	4,968	7
8	Accounts Receivable (owners or related parties)	48,749	(6,000)	8
9	Other(specify): <u>See Attached Schedule</u>	96,000	96,000	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,093,170	\$ 1,046,208	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		163,718	13
14	Buildings, at Historical Cost		2,378,189	14
15	Leasehold Improvements, at Historical Cost	26,822	195,217	15
16	Equipment, at Historical Cost	35,645	467,343	16
17	Accumulated Depreciation (book methods)	(2,827)	(146,388)	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>	24,002	107,784	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 83,642	\$ 3,165,863	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,176,812	\$ 4,212,071	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 517,283	\$ 517,284	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,858	22,858	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,988	122,988	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,425	7,425	31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,800	77,800	32
33	Accrued Interest Payable		17,927	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	7,115	7,115	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 755,469	\$ 773,397	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,096,207	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,096,207	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 755,469	\$ 3,869,604	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 421,343	\$ 342,467	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,176,812	\$ 4,212,071	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>96,000</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>96,000</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	325,343	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>325,343</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>421,343</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr# 0047738Report Period Beginning: 2/1/2006Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,897,755	1
2	Discounts and Allowances for all Levels	(1,608,900)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,288,855	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,393,605	6
7	Oxygen	180	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,393,785	8
<b>C. Other Operating Revenue</b>			
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	2,500	13
14	Non-Patient Meals	888	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,070	16
17	Sale of Drugs	145,697	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,439	19
20	Radiology and X-Ray	1,225	20
21	Other Medical Services	167,623	21
22	Laundry	13,732	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 353,174	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,747	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,747	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	6,568	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,568	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,045,129	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	757,399	31
32	Health Care	1,946,457	32
33	General Administration	1,092,027	33
<b>B. Capital Expense</b>			
34	Ownership	349,920	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	525,887	35
36	Provider Participation Fee	48,096	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,719,786	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	325,343	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 325,343	43

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

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

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

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

Facility Name & ID Number Beecher Manor Nrsng & Rehab Ctr

# 0047738

Report Period Beginning: 2/1/2006

Ending:

12/31/06

**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	1,692	1,875	\$ 59,414	\$ 31.69	1
2	Assistant Director of Nursing	686	869	18,907	21.76	2
3	Registered Nurses	16,902	18,395	489,361	26.60	3
4	Licensed Practical Nurses	13,385	14,518	323,333	22.27	4
5	CNAs & Orderlies	47,596	51,169	622,290	12.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,468	3,909	79,680	20.38	8
9	Activity Director	1,687	1,932	38,571	19.96	9
10	Activity Assistants	3,349	3,684	44,833	12.17	10
11	Social Service Workers	2,768	3,129	64,915	20.75	11
12	Dietician					12
13	Food Service Supervisor	1,736	1,875	35,720	19.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,306	5,874	60,568	10.31	15
16	Dishwashers	11,277	11,909	82,663	6.94	16
17	Maintenance Workers	4,966	5,629	99,377	17.65	17
18	Housekeepers	7,182	7,826	59,551	7.61	18
19	Laundry	660	683	5,785	8.47	19
20	Administrator	1,748	1,847	73,828	39.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,739	7,211	95,154	13.20	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	1,687	1,897	29,494	15.55	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	956	995	12,460	12.52	33
34	TOTAL (lines 1 - 33)	133,790	145,226	\$ 2,295,904 *	\$ 15.81	34

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

\*\* See instructions.

**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	114	\$ 5,164	01-03	35
36	Medical Director	monthly	12,650	09-03	36
37	Medical Records Consultant	monthly	1,030	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	720	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	196	11-03	44
45	Social Service Consultant	18	972	12-03	45
46	Other(specify)				46
47	<u>Therapy Consultant</u>	39	1,548	10A-03	47
48					48
49	TOTAL (lines 35 - 48)	175	\$ 22,280		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	768	\$ 44,800	10-03	50
51	Licensed Practical Nurses	135	5,045	10-03	51
52	Certified Nurse Assistants/Aides	481	11,617	10-03	52
53	TOTAL (lines 50 - 52)	1,384	\$ 61,462		53

SEE ACCOUNTANTS' COMPILATION REPORT



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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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. \$ 26,883 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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,096  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 888
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT