

Facility Name & ID Number Beecher Manor Nursing & Rehab Center

0047738 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 2/19/09

	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	109	Skilled (SNF)	130	46,421	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	109	TOTALS	130	46,421	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	22,377	6,043	5,956	34,376	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	22,377	6,043	5,956	34,376	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.05%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 2/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/01/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 5,749

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Beecher Manor Nursing & Rehab Center # 0047738 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	257,391	45,076	10,261	312,728		312,728	2,676	315,404		1
2	Food Purchase		173,952		173,952		173,952	(889)	173,063		2
3	Housekeeping	152,992	56,005		208,997		208,997	(2,868)	206,129		3
4	Laundry		1,853	104,821	106,674		106,674		106,674		4
5	Heat and Other Utilities			95,984	95,984		95,984	1,618	97,602		5
6	Maintenance	81,067		123,538	204,605		204,605	9,752	214,357		6
7	Other (specify):*							1,475	1,475		7
8	TOTAL General Services	491,450	276,886	334,604	1,102,940		1,102,940	11,764	1,114,704		8
	B. Health Care and Programs										
9	Medical Director			29,800	29,800		29,800		29,800		9
10	Nursing and Medical Records	1,946,504	123,691	29,345	2,099,540		2,099,540	14,374	2,113,914		10
10a	Therapy	148,530			148,530		148,530	6,717	155,247		10a
11	Activities	100,624	19,400		120,024		120,024		120,024		11
12	Social Services	103,118		4,497	107,615		107,615	6,180	113,795		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,569	5,569		15
16	TOTAL Health Care and Programs	2,298,776	143,091	63,642	2,505,509		2,505,509	32,840	2,538,349		16
	C. General Administration										
17	Administrative	106,252		19,800	126,052		126,052	36,153	162,205		17
18	Directors Fees										18
19	Professional Services			285,562	285,562		285,562	(231,286)	54,276		19
20	Dues, Fees, Subscriptions & Promotions			20,194	20,194		20,194	(8,668)	11,526		20
21	Clerical & General Office Expenses	122,508	27,665	93,114	243,287		243,287	50,477	293,764		21
22	Employee Benefits & Payroll Taxes			459,250	459,250		459,250	(6,593)	452,657		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,249	8,249		8,249	720	8,969		24
25	Other Admin. Staff Transportation			3,954	3,954		3,954	337	4,291		25
26	Insurance-Prop.Liab.Malpractice			101,464	101,464		101,464	891	102,355		26
27	Other (specify):*							21,061	21,061		27
28	TOTAL General Administration	228,760	27,665	991,587	1,248,012		1,248,012	(136,908)	1,111,104		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,018,986	447,642	1,389,833	4,856,461		4,856,461	(92,303)	4,764,158		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nursing & Rehab Center #0047738 Report Period Beginning: 01/01/09 Ending: 12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			93,858	93,858		93,858	269,903	363,761			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,344	8,344		8,344	495,570	503,914			32
33	Real Estate Taxes			49,318	49,318		49,318	1,543	50,861			33
34	Rent-Facility & Grounds			447,067	447,067		447,067	(440,782)	6,285			34
35	Rent-Equipment & Vehicles			11,396	11,396		11,396	1,714	13,110			35
36	Other (specify):*											36
37	TOTAL Ownership			609,983	609,983		609,983	327,948	937,931			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		361,607	520,513	882,120		882,120	(51,453)	830,667			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,632	69,632		69,632		69,632			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		361,607	590,145	951,752		951,752	(51,453)	900,299			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,018,986	809,249	2,589,961	6,418,196		6,418,196	184,192	6,602,388			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(959)	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	12,661	30		9
10	Interest and Other Investment Income	(7,990)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(306)	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				24
25	Fund Raising, Advertising and Promotional	(9,459)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(412)	20		28
29	Other-Attach Schedule	(74,288)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (80,752)		\$	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)	264,944		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 264,944		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 184,192		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Beecher Manor Nursing & Rehab Center

ID# 0047738

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Rental Income	\$ (2,317)	21	1
2	Jury Duty	(17)	21	2
3	Prior Period Expense	(11,494)	21	3
4	Theft Loss	(150)	21	4
5	Miscellaneous Income	(409)	21	5
6	Annual Report - Sec. of State	(250)	20	6
7	Marketing & Research	(171)	21	7
8	Non Allowable Legal Fees	(584)	19	8
9	Building Company - Administrative Expense	(250)	17	9
10	Building Company - Amortization Expense	(22,446)	36	10
11	Non Allowable Office Expense	(36,200)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(74,288)		49

Beecher Manor Nursing & Rehab Center

ID# 0047738

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beecher Manor Nursing & Rehab Center# 0047738

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			169		2,935	(1)				(427)		2,676	1
2	Food Purchase	(1,265)		376									(889)	2
3	Housekeeping			351		39	(3,258)						(2,868)	3
4	Laundry													4
5	Heat and Other Utilities			1,440		92					86		1,618	5
6	Maintenance			2,235	5,475	12	(78)		2,042		66		9,752	6
7	Other (specify):*				1,049	426							1,475	7
8	TOTAL General Services	(1,265)		4,571	6,524	3,504	(3,337)		2,042		(275)		11,764	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					19,982	(5,608)						14,374	10
10a	Therapy					1,149				5,568			6,717	10a
11	Activities													11
12	Social Services					6,180							6,180	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,569							5,569	15
16	TOTAL Health Care and Programs					32,880	(5,608)			5,568			32,840	16
	C. General Administration													
17	Administrative	(250)	250	1,649	5,978	26,065					2,461		36,153	17
18	Directors Fees													18
19	Professional Services	(584)		(178,714)		(52,192)			112		92		(231,286)	19
20	Fees, Subscriptions & Promotions	(10,121)		1,411		5					37		(8,668)	20
21	Clerical & General Office Expenses	(50,758)		11,549	89,914	5,845			(9,052)		2,979		50,477	21
22	Employee Benefits & Payroll Taxes				(3,186)	(3,358)	(49)						(6,593)	22
23	Inservice Training & Education													23
24	Travel and Seminar			44		676							720	24
25	Other Admin. Staff Transportation			258					9		70		337	25
26	Insurance-Prop.Liab.Malpractice			566		34			116		175		891	26
27	Other (specify):*				15,459	4,528					1,074		21,061	27
28	TOTAL General Administration	(61,713)	250	(163,237)	108,165	(18,397)	(49)		(8,815)		6,888		(136,908)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(62,978)	250	(158,666)	114,689	17,987	(8,994)		(6,773)	5,568	6,613		(92,303)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beecher Manor Nursing & Rehab Center# 0047738

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	12,661	240,714	2,887		639			12,822		180		269,903	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,990)	451,154	42,431		7,723			2,252				495,570	32
33	Real Estate Taxes			1,392		151							1,543	33
34	Rent-Facility & Grounds		(444,000)	2,414							804		(440,782)	34
35	Rent-Equipment & Vehicles			1,705							9		1,714	35
36	Other (specify):*	(22,446)	22,446											36
37	TOTAL Ownership	(17,775)	270,314	50,829		8,513			15,074		993		327,948	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(6,020)		(20,750)	(20,996)	(3,687)		(51,453)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(6,020)		(20,750)	(20,996)	(3,687)		(51,453)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(80,752)	270,564	(107,837)	114,689	26,500	(15,014)		(12,449)	(15,428)	3,919		184,192	45

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
See Attached		See Attached		See Attached		
				Beecher Properties, LLC		Building Company

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	\$ 444,000	Beecher Properties, LLC	100.00%	\$	(444,000)	1
2	V	33 Real Estate Tax	49,318	Beecher Properties, LLC	100.00%	49,318		2
3	V	17 Adminisitrative Expense		Beecher Properties, LLC	100.00%	250	250	3
4	V	30 Depreciation		Beecher Properties, LLC	100.00%	240,714	240,714	4
5	V	36 Amortization Expense		Beecher Properties, LLC	100.00%	22,446	22,446	5
6	V	32 Interest Expense		Beecher Properties, LLC	100.00%	451,154	451,154	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 493,318			\$ 763,882	\$ * 270,564	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 169	\$	169	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	376		376	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	351		351	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,440		1,440	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	2,235		2,235	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,649		1,649	20
21	V	19 Professional Fees	183,796	Extended Care Consulting, LLC	100.00%	7,132		(178,714)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,411		1,411	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	11,549		11,549	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	44		44	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	258		258	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	566		566	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	2,887		2,887	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	42,431		42,431	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,392		1,392	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	2,414		2,414	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,705		1,705	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 183,796			\$ 78,009	\$ *	(107,837)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	5,475	\$	5,475	15
16	V	06 Maintenance (Direct)	9,556	Extended Care Consulting, LLC	100.00%	9,556			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	937		937	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	112		112	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	5,978		5,978	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	89,914		89,914	20
21	V	21 Office and Clerical (Direct)	6,374	Extended Care Consulting, LLC	100.00%	6,374			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	15,384		15,384	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	75		75	23
24	V	22 Employee Benefits	3,186	Extended Care Consulting, LLC	100.00%			(3,186)	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		\$ 19,116			\$ 133,805	\$ *	114,689	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 39	\$	39	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	92		92	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	12		12	17
18	V	19 Professional Fees	52,994	Extended Care Clinical, LLC	100.00%	802		(52,192)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	5		5	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	682		682	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	676		676	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	34		34	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	639		639	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	7,723		7,723	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	151		151	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	2,935		2,935	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	426		426	27
28	V	10 Nursing Salary	12,291	Extended Care Clinical, LLC	100.00%	32,273		19,982	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	1,149		1,149	29
30	V	12 Social Service Salary	4,497	Extended Care Clinical, LLC	100.00%	10,677		6,180	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	5,569		5,569	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	26,065		26,065	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	5,163		5,163	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	4,528		4,528	34
35	V	22 Employee Benefits	3,358	Extended Care Clinical, LLC	100.00%			(3,358)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 73,140			\$ 99,640	\$ *	26,500	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	<u>1 Dietary</u>	\$ 14	<u>Xcel Supply, LLC</u>	100.00%	\$ 13	\$ (1)
16	V	<u>3 Housekeeping</u>	35,482	<u>Xcel Supply, LLC</u>	100.00%	32,223	(3,258)
17	V	<u>4 Laundry</u>		<u>Xcel Supply, LLC</u>	100.00%		
18	V	<u>6 Repairs & Maintenance</u>	845	<u>Xcel Supply, LLC</u>	100.00%	767	(78)
19	V	<u>10 Nursing</u>	61,066	<u>Xcel Supply, LLC</u>	100.00%	55,458	(5,608)
20	V	<u>11 Activities</u>		<u>Xcel Supply, LLC</u>	100.00%		
21	V	<u>12 Social Service</u>		<u>Xcel Supply, LLC</u>	100.00%		
22	V	<u>20 Dues, Fees And Subscriptions</u>		<u>Xcel Supply, LLC</u>	100.00%		
23	V	<u>21 Office And Clerical</u>		<u>Xcel Supply, LLC</u>	100.00%		
24	V	<u>22 Employee Benefits</u>	536	<u>Xcel Supply, LLC</u>	100.00%	487	(49)
25	V	<u>24 Seminars & Education</u>		<u>Xcel Supply, LLC</u>	100.00%		
26	V	<u>39 Ancillary</u>	65,551	<u>Xcel Supply, LLC</u>	100.00%	59,532	(6,020)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 163,494			\$ 148,480	\$ * (15,014)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 203,592	\$ 203,592
16	V						
17	V						
18	V						
19	V	22 Employee Health Insurance	203,592	CCS Employee Benefits Group	100.00%		(203,592)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 203,592			\$ 203,592	\$ *

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 2,042	\$	2,042	15
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	112		112	16
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	173		173	17
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	9		9	18
19	V	26 Insurance		Vent Lease, LLC.	100.00%	116		116	19
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	5,314		5,314	20
21	V	32 Interest		Vent Lease, LLC.	100.00%	895		895	21
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	7,508		7,508	22
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	1,357		1,357	23
24	V	21 Office and Clerical	9,225	Vent Lease, LLC.	100.00%			(9,225)	24
25	V	39 Ancillary	20,750	Vent Lease, LLC.	100.00%			(20,750)	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		\$ 29,975			\$ 17,526	\$ *	(12,449)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 THERAPY	\$ 440,807	TRICARE REHAB		\$ 419,811	\$ (20,996)
16	V	10A REHAB				5,568	5,568
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 440,807			\$ 425,379	\$ * (15,428)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 1,133	\$ 1,133	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	86	86	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	66	66	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	92	92	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	37	37	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	466	466	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	70	70	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	175	175	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	180	180	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%			25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	804	804	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	9	9	28
29	V	01 Dietary	2,597	Care Centers Health Systems, Inc.	100.00%	1,037	(1,560)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%			30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%			32
33	V	22 Employee Benefits		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary	6,137	Care Centers Health Systems, Inc.	100.00%	2,450	(3,687)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	2,461	2,461	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,513	2,513	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,074	1,074	38
39	Total		\$ 8,734			\$ 12,653	\$ * 3,919	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Beecher Manor Nursing & Rehab Center # 0047738 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	Owner	Administrative	0.50%	See Attached	0.75	2.50%	Mgmt. Fees	\$ 3,800	17-3	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.37	2.49%	Alloc. Salary	4,160	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	1.19	2.98%	Alloc. Salary	2,136	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,096		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center # 0047738 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Nursing & Rehab Center

0047738

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	30	\$ 6,770	\$	34,376	\$ 169	1
2	02	Food	Patient Days	30	15,058		34,376	376	2
3	03	Housekeeping	Patient Days	30	14,059		34,376	351	3
4	05	Utilities	Patient Days	30	57,646		34,376	1,440	4
5	06	Maintenance	Patient Days	30	89,465		34,376	2,235	5
6	17	Administrative	Patient Days	30	66,000		34,376	1,649	6
7	19	Professional Fees	Patient Days	30	285,482		34,376	7,132	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		34,376	1,411	8
9	21	Office and Clerical	Patient Days	30	462,313		34,376	11,549	9
10	24	Seminar and Travel	Patient Days	30	1,768		34,376	44	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		34,376	258	11
12	26	Insurance	Patient Days	30	22,668		34,376	566	12
13	30	Depreciation	Patient Days	30	115,549		34,376	2,887	13
14	32	Interest	Patient Days	30	1,698,489		34,376	42,431	14
15	33	Real Estate Taxes	Patient Days	30	55,709		34,376	1,392	15
16	34	Rent - Building	Patient Days	30	96,636		34,376	2,414	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		34,376	1,705	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 78,009	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center

0047738

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,376,056	30	219,177	219,177	34,376	5,475	1
2	06	Maintenance (Direct)	Direct		30	82,905	82,905		9,556	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,376,056	30	37,501		34,376	937	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	8,464	8,464		112	4
5	17	Administrative (Pooled)	Patient Days	1,376,056	30	239,303	239,303	34,376	5,978	5
6	21	Office and Clerical (Pooled)	Patient Days	1,376,056	30	3,599,211	3,599,211	34,376	89,914	6
7	21	Office and Clerical (Direct)	Direct		30	654,174			6,374	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,376,056	30	615,819	615,819	34,376	15,384	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	73,650	73,650	34,376	75	9
10	22	Employee Benefits								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					\$ 5,530,203	\$ 4,838,529		\$ 133,805	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center

0047738

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	03	Housekeeping	Patient Days	1,376,056	30	\$ 1,549	\$ 34,376	\$ 39	1	
2	05	Utilities	Patient Days	1,376,056	30	3,693	34,376	92	2	
3	06	Maintenance	Patient Days	1,376,056	30	477	34,376	12	3	
4	19	Professional Fees	Patient Days	1,376,056	30	32,105	34,376	802	4	
5	20	Dues and Subscriptions	Patient Days	1,376,056	30	213	34,376	5	5	
6	21	Office & Clerical	Patient Days	1,376,056	30	27,296	34,376	682	6	
7	24	Travel and Seminar	Patient Days	1,376,056	30	27,079	34,376	676	7	
8	26	Insurance	Patient Days	1,376,056	30	1,342	34,376	34	8	
9	30	Depreciation	Patient Days	1,376,056	30	25,586	34,376	639	9	
10	32	Interest	Patient Days	1,376,056	30	309,136	34,376	7,723	10	
11	33	Real Estate Taxes	Patient Days	1,376,056	30	6,053	34,376	151	11	
12	01	Dietary Salary	Patient Days	1,376,056	30	117,506	34,376	2,935	12	
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,376,056	30	17,040	34,376	426	13	
14	10	Nursing Salary	Patient Days	1,376,056	30	799,889	799,889	34,376	19,982	14
15	10a	Rehab Salary	Patient Days	1,376,056	30	45,993	45,993	34,376	1,149	15
16	12	Social Service Salary	Patient Days	1,376,056	30	247,396	247,396	34,376	6,180	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,376,056	30	158,537	34,376	3,960	17	
18	17	Administration Salary	Patient Days	1,376,056	30	1,043,375	1,043,375	34,376	26,065	18
19	21	Office Salary	Patient Days	1,376,056	30	206,680	206,680	34,376	5,163	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,376,056	30	181,271	34,376	4,528	20	
21	10	Nursing Salary	Direct Allocation			494,488	494,488	34,376	12,291	21
22	12	Social Service Salary	Direct Allocation			196,033	196,033		4,497	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			82,560			1,609	23
24										24
25	TOTALS					\$ 4,025,296	\$ 3,151,360	\$ 99,640	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center

0047738

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	1	Dietary	Direct Allocation		\$	\$		13	1
2	3	Housekeeping	Direct Allocation					32,223	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation					767	4
5	10	Nursing	Direct Allocation					55,458	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					487	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					59,532	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				\$	\$		148,480	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center

0047738

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 203,592	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				\$	\$		\$ 203,592	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center

0047738

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	821,185	26	\$ 80,807	\$ 20,750	\$ 2,042	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	20,750	112	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	20,750	173	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	20,750	9	4
5	26	Insurance	Direct Billing	821,185	26	4,573	20,750	116	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	20,750	5,314	6
7	32	Interest	Direct Billing	821,185	26	35,420	20,750	895	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	34,376	7,508	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	34,376	1,357	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					\$ 706,114	\$	\$ 17,526	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center

0047738

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	39	THERAPY	DIRECT ALLOCATION		\$	\$		\$ 419,811	1
2	10A	REHAB	DIRECT ALLOCATION					5,568	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				\$	\$		\$ 425,379	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center

0047738

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

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	01	Dietary	Gross Billable Income	3,421,940	26	72,652	53,376	1,133	1
2	03	Housekeeping	Gross Billable Income	3,421,940	26		53,376		2
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	53,376	86	3
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	53,376	66	4
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	53,376	92	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	53,376	37	6
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	53,376	466	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	53,376	70	8
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	53,376	175	9
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	53,376	180	10
11	32	Interest	Gross Billable Income	3,421,940	26		53,376		11
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		53,376		12
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	53,376	804	13
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	53,376	9	14
15	01	Dietary	Direct Billable Income	206,522	26	82,445	2,597	1,037	15
16	02	Food	Direct Billable Income	2,784	26	1,111			16
17	03	Housekeeping	Direct Billable Income		26				17
18	10	Nursing	Direct Billable Income	5,466	26	2,182			18
19	22	Employee Benefits	Direct Billable Income	411	26	164			19
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	6,137	2,450	21
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	2,461	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	2,513	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	53,376	1,074	24
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 12,653	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center

0047738

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Central Illinois Bank		X	Mortgage			\$	\$ 8,217,570		\$ 451,155	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	Central Illinois Bank		X	Line of Credit						7,703	6								
7	Xerox		X					4,962		641	7								
8	See Supplemental Schedule									52,406	8								
9	TOTAL Facility Related						\$	\$ 8,222,532		\$ 511,905	9								
B. Non-Facility Related*																			
10	Interest Income		X							(7,990)	10								
11											11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ (7,990)	14								
15	TOTALS (line 9+line14)						\$	\$ 8,222,532		\$ 503,915	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 Nursing & Rehab Center

0047738

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8	Alloc. EC Consulting		X							\$ 42,431	8									
9	Alloc. EC Clinical		X							7,723	9									
10	Alloc. Vent Lease		X							2,252	10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15											15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,799 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>123,116</u>	<u>2006</u>	<u>\$ 163,718</u>	<u>1</u>
2	<u>Allocated from EC Consulting 2201/Clinical 2201</u>			<u>9,168</u>	<u>2</u>
3	TOTALS	123,116		\$ 172,886	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Beecher Manor Nursing & Rehab Center**

0047738

Report Period Beginning:

01/01/09

Ending:

12/31/09

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
	Improvement Type**										
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

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	Related Building Company (Pages 12F & 12G)	7,959,613	192,536		192,536		397,631	67
68	Related Party Allocations (Pages 12H & 12I)	36,277	2,479		2,479		15,091	68
69	Financial Statement Depreciation		76,971			(76,971)		69
70	TOTAL (lines 4 thru 69)	\$ 7,995,890	\$ 271,986		\$ 195,015	\$ (76,971)	\$ 412,722	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Beecher Manor Nursing & Rehab Center# 0047738

Report Period Beginning:

01/01/09

Ending:

12/31/09**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 12A, Carried Forward		\$ 7,995,890	\$ 271,986		\$ 195,015	\$ (76,971)	\$ 412,722	1
2	Doors	2006	4,300		20	215	215	842	2
3	Conduit Instalation	2006	4,485		20	224	224	878	3
4	Fire Rated Wall	2006	3,800		20	190	190	633	4
5	Facility Signs	2006	3,302		20	165	165	537	5
6	Electrical Outlets	2006	2,700		20	135	135	428	6
7	Fire Doors	2006	8,235		20	412	412	1,304	7
8	Cabinets	2006	14,800		20	740	740	2,467	8
9	Hvac Units	2006	2,961		20	148	148	481	9
10	Smoke Detectors	2007	3,875		20	194	194	565	10
11	Shower Stalls	2007	28,944		20	1,447	1,447	4,100	11
12	5 Ton Condenser Unit	2007	2,614		20	523	523	1,263	12
13	Cable For Phones	2008	4,236		20	212	212	406	13
14	Phone System	2008	16,471		20	824	824	1,510	14
15	Call System	2008	1,142		20	57	57	105	15
16	Door Alert System	2008	5,555		20	278	278	509	16
17	Shower Floors	2008	7,563		20	378	378	662	17
18	Shower Floors	2008	7,536		20	377	377	659	18
19	Shower Floors	2008	5,042		20	252	252	420	19
20	Call System	2008	8,177		20	409	409	681	20
21	Cocerhead Light Switches	2008	3,500		20	175	175	292	21
22	Lock Systems	2008	3,141		20	157	157	262	22
23	Blinds	2008	4,266		20	427	427	640	23
24	Shower Stalls	2008	5,042		20	252	252	378	24
25	Sprinkler Placard	2008	3,500		20	175	175	219	25
26	Telephone Wiring	2008	6,596		20	330	330	412	26
27	Fire Panel	2008	2,550		20	128	128	159	27
28	Paint	2008	3,072		20	154	154	192	28
29	Nurse Call System	2008	2,983		20	149	149	186	29
30	Magnetic Locks	2008	3,587		20	179	179	224	30
31	Painting (Transfer From Home Office)	2008	6,063		20	4,547	4,547	6,063	31
32	Painting (Transfer From Home Office)	2008	7,345		20	6,121	6,121	7,345	32
33	Painting	2009	7,481		20	7,481	7,481	7,481	33
34	TOTAL (lines 1 thru 33)		\$ 8,190,754	\$ 271,986		\$ 222,470	\$ (49,516)	\$ 455,025	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		\$ 8,190,754	\$ 271,986		\$ 222,470	\$ (49,516)	\$ 455,025	1
2	2009	3,601		20	180	180	180	2
3	2009	3,335		20	3,335	3,335	3,335	3
4	2009	2,910		20	146	146	146	4
5	2009	4,050		20	810	810	810	5
6	2009	3,968		20	794	794	794	6
7	2009	8,050		20	7,379	7,379	7,379	7
8	2009	19,007		20	15,839	15,839	15,839	8
9	2009	4,995		20	125	125	125	9
10	2009	13,640		20	227	227	227	10
11	2009	5,640		20	71	71	71	11
12	2009	30,909		20	1,545	1,545	1,545	12
13	2009	3,087		20	154	154	154	13
14	2009	3,195		20	160	160	160	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		\$ 8,297,141	\$ 271,986		\$ 253,236	\$ (18,750)	\$ 485,790	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		\$ 8,297,141	\$ 271,986		\$ 253,236	\$ (18,750)	\$ 485,790	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)	\$ 8,297,141	\$ 271,986		\$ 253,236	\$ (18,750)	\$ 485,790	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,297,141	\$ 271,986		\$ 253,236	\$ (18,750)	\$ 485,790	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)		\$ 8,297,141	\$ 271,986		\$ 253,236	\$ (18,750)	\$ 485,790	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Beecher Properties, LLC	1985	2,546,584	65,215	39	65,215		253,025	3
4	2008 Additions	2008	1,794,872	46,021	39	46,021		63,306	4
5	2009 Additions	2009	3,653,332	81,300	39	81,300		81,300	5
6	2009 Additions	2009	(35,175)						6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									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							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 7,959,613	\$ 192,536		\$ 192,536	\$	\$ 397,631

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main, LLC	2002	11,381	292	39	292		2,128	3
4	Allocated from Extended Care Clinical 2201 Main, LLC	2002	1,254	32	39	32		234	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	115	2	20	2		13	9
10	Allocated from Extended Care Consulting, LLC	2009	69	3	20	3		3	10
11									11
12	Allocated from Extended Care Consulting 2201 Main, LLC	2002	9,401	859	20	859		5,163	12
13	Allocated from Extended Care Consulting 2201 Main, LLC	2003	11,079	1,013	20	1,013		6,085	13
14	Allocated from Extended Care Consulting 2201 Main, LLC	2005	550	59	20	59		198	14
15	Allocated from Extended Care Consulting 2201 Main, LLC	2009	99	5	20	5		5	15
16									16
17	Allocated from Extended Care Clinical 2201 Main, LLC	2002	1,036	95	20	95		569	17
18	Allocated from Extended Care Clinical 2201 Main, LLC	2003	1,221	112	20	112		670	18
19	Allocated from Extended Care Clinical 2201 Main, LLC	2005	61	6	20	6		22	19
20	Allocated from Extended Care Clinical 2201 Main, LLC	2009	11	1	20	1		1	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

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								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 (12H & 12I lines 1 thru 33)		\$ 36,277	\$ 2,479		\$ 2,479	\$ 15,091	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 519,908	\$ 73,969	\$ 101,003	\$ 27,034	10	\$ 378,011	71
72	Current Year Purchases	69,394	4,568	8,946	4,378	10	8,946	72
73	Fully Depreciated Assets	79,409				10	79,409	73
74								74
75	TOTALS	\$ 668,711	\$ 78,538	\$ 109,949	\$ 31,411		\$ 466,366	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		Allocated from Extended Care Cc	2009	\$ 8,033	\$ 125	\$ 125		5	\$ 7,657	76
77		Allocated from Extended Care Cl	2009	1,796	359	359		5	1,058	77
78		Allocated from Care Centers Hea	2009	457	91	91		5	137	78
79										79
80	TOTALS			\$ 10,286	\$ 575	\$ 575			\$ 8,852	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,149,024	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 351,098	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 363,760	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,661	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 961,008	85

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

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

G. Construction-in-Progress

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

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

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

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	<u>Storage Rental</u>		<u>3,067</u>			4
5	<u>Allocated from Extended Care Consulting</u>			<u>2,414</u>			5
6	<u>Allocated from Care Centers Health Systems</u>			<u>804</u>			6
7	TOTAL			\$ <u>6,285</u>			7

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 13,110 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	219,782	\$		\$	219,782	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				22,060				22,060	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				240,343				240,343	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					206,899			206,899	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): See Supplemental						38,328	154,708			193,036	13
14	TOTAL			\$		\$	520,513	\$	361,607	\$	882,120	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 Nursing & Rehab Center# 0047738Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 228,581	\$ 230,359	1
2	Cash-Patient Deposits	31,589	31,589	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	521,474	521,474	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,934	78,934	6
7	Other Prepaid Expenses	5,934	5,934	7
8	Accounts Receivable (owners or related parties)	317,722	96,000	8
9	Other(specify): <u>See Attached Schedule</u>	119,674	119,674	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,303,908	\$ 1,083,964	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		163,718	13
14	Buildings, at Historical Cost		7,959,613	14
15	Leasehold Improvements, at Historical Cost	268,610	268,610	15
16	Equipment, at Historical Cost	192,346	624,044	16
17	Accumulated Depreciation (book methods)	(155,134)	(908,312)	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>	8,438	110,394	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 314,260	\$ 8,218,067	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,618,168	\$ 9,302,031	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 512,070	\$ 512,068	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,077	31,077	28
29	Short-Term Notes Payable	4,962	4,962	29
30	Accrued Salaries Payable	182,107	182,107	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,015	7,015	31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,499	52,499	32
33	Accrued Interest Payable		42,468	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	456	10,549	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 790,186	\$ 842,745	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,217,568	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,217,568	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 790,186	\$ 9,060,313	46
47	TOTAL EQUITY(page 18, line 24)	\$ 827,982	\$ 241,718	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,618,168	\$ 9,302,031	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 409,698	1
2	Restatements (describe):		2
3	Dividends	65,000	3
4	Other Professional Fees/Illinois Replacement Tax	(15,950)	4
5	Rounding	3	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 458,751	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	559,231	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(190,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 369,231	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 827,982	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Beecher Manor Nursing & Rehab Center**# **0047738**Report Period Beginning: **01/01/09**Ending: **12/31/09**

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,840,627	1
2	Discounts and Allowances for all Levels	(2,301,270)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,539,357	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,903,904	6
7	Oxygen	1,744	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,905,648	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	219	13
14	Non-Patient Meals	959	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,317	16
17	Sale of Drugs	208,147	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,351	19
20	Radiology and X-Ray	4,125	20
21	Other Medical Services	229,045	21
22	Laundry	21,043	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 496,206	23
D. Non-Operating Revenue			
24	Contributions	25,000	24
25	Interest and Other Investment Income***	7,990	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32,990	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,226	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,226	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,977,427	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,102,940	31
32	Health Care	2,505,509	32
33	General Administration	1,248,012	33
B. Capital Expense			
34	Ownership	609,983	34
C. Ancillary Expense			
35	Special Cost Centers	882,120	35
36	Provider Participation Fee	69,632	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,418,196	40
41	Income before Income Taxes (line 30 minus line 40)**	559,231	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 559,231	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 Nursing & Rehab Center**

0047738

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1,902	1,990	\$ 85,333	\$ 42.88	1
2	Assistant Director of Nursing	1,842	1,912	72,058	37.69	2
3	Registered Nurses	16,068	17,838	540,118	30.28	3
4	Licensed Practical Nurses	18,132	20,452	484,042	23.67	4
5	CNAs & Orderlies	55,084	60,082	698,813	11.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,653	8,820	148,530	16.84	8
9	Activity Director	1,825	2,147	46,845	21.82	9
10	Activity Assistants	4,376	4,696	53,779	11.45	10
11	Social Service Workers	4,882	5,402	103,118	19.09	11
12	Dietician					12
13	Food Service Supervisor	1,722	2,004	40,288	20.10	13
14	Head Cook	6,174	6,823	85,936	12.60	14
15	Cook Helpers/Assistants					15
16	Dishwashers	14,252	15,824	131,167	8.29	16
17	Maintenance Workers	3,656	4,149	81,067	19.54	17
18	Housekeepers	14,459	15,837	152,992	9.66	18
19	Laundry					19
20	Administrator	1,925	2,162	106,252	49.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,780	8,549	122,508	14.33	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	1,733	2,006	34,518	17.21	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,909	2,164	31,622	14.61	33
34	TOTAL (lines 1 - 33)	165,374	182,857	\$ 3,018,986 *	\$ 16.51	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	225	\$ 10,261	01-03	35
36	Medical Director	Monthly	29,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,440	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	<u>See Attached</u>		16,788		48
49	TOTAL (lines 35 - 48)	225	\$ 58,289		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	41	\$ 2,359	10-03	50
51	Licensed Practical Nurses	23	1,018	10-03	51
52	Certified Nurse Assistants/Aides	518	12,236	10-03	52
53	TOTAL (lines 50 - 52)	582	\$ 15,613		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Marcia Quale	Administrator	0	\$ 106,252	Workers' Compensation Insurance	\$ 68,516	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	30,840	Advertising: Employee Recruitment	3,799	
				FICA Taxes	224,586	Health Care Worker Background Check		
				Employee Health Insurance	112,141	(Indicate # of checks performed <u>275</u>)	3,879	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	963	
				Employee Physicals	7,111	Licenses & Permits	437	
				Other Employee Welfare	7,882	Advertising & Promotion	9,459	
				Holiday Expense	1,581	Alloc. From Extended Care Consulting	1,411	
						See Supplemental Schedule	454	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(9,459)	
						Yellow page advertising	(412)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,252	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 452,657		\$ 11,526		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - E. Rothner			\$ 3,800				Out-of-State Travel	\$
Management Fees - D. Aronin			8,000					
Management Fees - S. Miretsky			8,000				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 19,800	TOTAL		\$	Seminar Expense	1,275
							Inservice Training	6,599
							Education	375
							See Supplemental Schedule	720
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 285,561				TOTAL	\$ 8,969

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2006					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beecher Manor Nursing & Rehab Center# 0047738

Report Period Beginning:

01/01/09

Ending:

12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47,302 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 69,632
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? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.