

Facility Name & ID Number Beecher Manor N & R Ctr

0047738 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	130	Skilled (SNF)	130	47,450	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	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	24,185	6,924	8,540	39,649	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,185	6,924	8,540	39,649	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.56%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 128 and days of care provided 7,977

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number

Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	356,304	62,000	23,826	442,130		442,130	4,088	446,218		1
2	Food Purchase		248,516		248,516		248,516	(460)	248,056		2
3	Housekeeping	192,622	29,832		222,454		222,454	511	222,965		3
4	Laundry		4,110	192,416	196,526		196,526		196,526		4
5	Heat and Other Utilities			121,315	121,315		121,315	1,119	122,434		5
6	Maintenance	137,448		307,325	444,773		444,773	(29,442)	415,331		6
7	Other (specify):*							4,929	4,929		7
8	TOTAL General Services	686,374	344,458	644,882	1,675,714		1,675,714	(19,255)	1,656,459		8
	B. Health Care and Programs										
9	Medical Director			20,000	20,000		20,000		20,000		9
10	Nursing and Medical Records	2,599,237	241,429	8,589	2,849,255		2,849,255	36,264	2,885,519		10
10a	Therapy	185,089			185,089		185,089		185,089		10a
11	Activities	145,384	25,099		170,483		170,483		170,483		11
12	Social Services	166,066			166,066		166,066	16,524	182,590		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							6,050	6,050		15
16	TOTAL Health Care and Programs	3,095,776	266,528	28,589	3,390,893		3,390,893	58,838	3,449,731		16
	C. General Administration										
17	Administrative	78,952			78,952		78,952	74,770	153,722		17
18	Directors Fees										18
19	Professional Services			520,281	520,281		520,281	(436,669)	83,612		19
20	Dues, Fees, Subscriptions & Promotions			61,620	61,620		61,620	(26,362)	35,258		20
21	Clerical & General Office Expenses	80,075	62,665	146,754	289,494		289,494	72,671	362,165		21
22	Employee Benefits & Payroll Taxes			673,872	673,872		673,872	(15,837)	658,035		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,892	2,892		2,892	1,327	4,219		24
25	Other Admin. Staff Transportation			7,319	7,319		7,319	456	7,775		25
26	Insurance-Prop.Liab.Malpractice			129,468	129,468		129,468	1,609	131,077		26
27	Other (specify):*							30,377	30,377		27
28	TOTAL General Administration	159,027	62,665	1,542,206	1,763,898		1,763,898	(297,658)	1,466,240		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,941,177	673,651	2,215,677	6,830,505		6,830,505	(258,075)	6,572,430		29

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

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

Facility Name & ID Number

Beecher Manor N & R Ctr

#0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			64,108	64,108		64,108	188,448	252,556			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,219	12,219		12,219	383,529	395,748			32
33	Real Estate Taxes			170,696	170,696		170,696	2,493	173,189			33
34	Rent-Facility & Grounds			744,000	744,000		744,000	(744,000)				34
35	Rent-Equipment & Vehicles			3,502	3,502		3,502	639	4,141			35
36	Other (specify):*											36
37	TOTAL Ownership			994,525	994,525		994,525	(168,891)	825,634			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		607,633	823,021	1,430,654		1,430,654	(60,113)	1,370,541			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			270,562	270,562		270,562		270,562			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		607,633	1,093,583	1,701,216		1,701,216	(60,113)	1,641,103			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,941,177	1,281,284	4,303,785	9,526,246		9,526,246	(487,079)	9,039,167			45

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

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	(20)	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	(20,406)	30		9
10	Interest and Other Investment Income	(33,117)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(434)	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	(899)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,971)	21		24
25	Fund Raising, Advertising and Promotional	(23,241)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(73,722)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (189,810)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	(297,270)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (297,270)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (487,079)		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

Beecher Manor N & R Ctr

ID# 0047738

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (581)	02	1
2	Other Income	(510)	21	2
3	Jury Duty	(161)	10	3
4	Theft Loss	(813)	21	4
5	Collection Expense	(5,682)	21	5
6	PAC Dues	(3,447)	20	6
7	Non-allowable Dues	(400)	20	7
8	Non-allowable Professional Fees	(3,575)	19	8
9	Non-allowable Travel	(631)	25	9
10	Non-allowable Legal	(6,844)	19	10
11	Capitalized R&M	(2,980)	06	11
12	Building Company - Management Fee	(1,588)	21	12
13	Building Company - Administrative Expense	(250)	21	13
14	Building Company - Amortization Expense	(8,771)	31	14
15	Capitalized R&M	(37,489)	06	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(73,722)	49

Beecher Manor N & R Ctr

ID# 0047738

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beecher Manor N & R Ctr# 0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			129		3,959							4,088	1
2	Food Purchase	(1,035)		575									(460)	2
3	Housekeeping			430		81							511	3
4	Laundry													4
5	Heat and Other Utilities			970		149							1,119	5
6	Maintenance	(40,469)		4,004	6,900	123							(29,442)	6
7	Other (specify):*				4,477	452							4,929	7
8	TOTAL General Services	(41,504)		6,108	11,377	4,764							(19,255)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(161)				36,477					(52)		36,264	10
10a	Therapy													10a
11	Activities													11
12	Social Services					16,524							16,524	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,050							6,050	15
16	TOTAL Health Care and Programs	(161)				59,051					(52)		58,838	16
	C. General Administration													
17	Administrative			2,661	14,388	57,721							74,770	17
18	Directors Fees													18
19	Professional Services	(10,419)		(318,379)		(107,871)							(436,669)	19
20	Fees, Subscriptions & Promotions	(27,987)		1,414		211							(26,362)	20
21	Clerical & General Office Expenses	(46,814)	1,838	9,681	84,424	23,542							72,671	21
22	Employee Benefits & Payroll Taxes				(15,837)								(15,837)	22
23	Inservice Training & Education													23
24	Travel and Seminar			221		1,106							1,327	24
25	Other Admin. Staff Transportation	(631)		1,087									456	25
26	Insurance-Prop.Liab.Malpractice			1,168		441							1,609	26
27	Other (specify):*				21,239	9,138							30,377	27
28	TOTAL General Administration	(85,851)	1,838	(302,147)	104,214	(15,712)							(297,658)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(127,516)	1,838	(296,039)	115,591	48,103					(52)		(258,075)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14 Ending:

12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(20,406)	204,214	3,600		1,040							188,448	30
31	Amortization of Pre-Op. & Org.	(8,771)	8,771											31
32	Interest	(33,117)	386,354	824		29,468							383,529	32
33	Real Estate Taxes			2,098		395							2,493	33
34	Rent-Facility & Grounds		(744,000)										(744,000)	34
35	Rent-Equipment & Vehicles			639									639	35
36	Other (specify):*													36
37	TOTAL Ownership	(62,294)	(144,661)	7,161		30,903							(168,891)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(767)	(58,537)			(809)		(60,113)	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						(767)	(58,537)			(809)		(60,113)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(189,810)	(142,823)	(288,878)	115,591	79,006	(767)	(58,537)			(861)		(487,079)	45

Facility Name & ID Number

Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 744,000	Beecher Properties, LLC	100.00%	\$	\$(744,000)	1
2	V	21 Management Fees		Beecher Properties, LLC	100.00%	1,588	1,588	2
3	V	21 Administrative Expense		Beecher Properties, LLC	100.00%	250	250	3
4	V	30 Depreciation Expense		Beecher Properties, LLC	100.00%	204,214	204,214	4
5	V	31 Amortization Expense		Beecher Properties, LLC	100.00%	8,771	8,771	5
6	V	32 Interest Expense		Beecher Properties, LLC	100.00%	386,354	386,354	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 744,000			\$ 601,177	\$ * (142,823)	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%	\$ 129	\$	129	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	575		575	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	430		430	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	970		970	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	4,004		4,004	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,661		2,661	20
21	V	19 Professional Fees	325,968	Extended Care Consulting, LLC	100.00%	7,589		(318,379)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,414		1,414	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	9,681		9,681	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	221		221	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,087		1,087	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,168		1,168	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	3,600		3,600	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	824		824	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,098		2,098	29
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	639		639	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 325,968			\$ 37,090	\$ *	(288,878)	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%	6,900	\$	6,900	15
16	V	06 Maintenance (Direct)	33,372	Extended Care Consulting, LLC	100.00%	33,372			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	655		655	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	3,822		3,822	18
19	V								19
20	V								20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	14,388		14,388	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	84,424		84,424	22
23	V	21 Office and Clerical (Direct)	19,420	Extended Care Consulting, LLC	100.00%	19,420			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	18,200		18,200	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,039		3,039	25
26	V	22 Employee Benefits	15,837	Extended Care Consulting, LLC	100.00%			(15,837)	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		\$ 68,629			\$ 184,220	\$ *	115,591	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%	\$ 81	\$	81	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	149		149	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	123		123	17
18	V	19 Professional Fees	108,660	Extended Care Clinical, LLC	100.00%	789		(107,871)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	211		211	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,217		1,217	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,106		1,106	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	441		441	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	1,040		1,040	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	29,468		29,468	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	395		395	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	3,959		3,959	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	452		452	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	36,477		36,477	28
29	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	16,524		16,524	29
30	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,050		6,050	30
31	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	57,721		57,721	31
32	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	22,325		22,325	32
33	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	9,138		9,138	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 108,660			\$ 187,666	\$ *	79,006	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 Various Equipment	8,620	Vent Lease LLC	100.00%	7,853	\$ (767)
16	V						
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		\$ 8,620			\$ 7,853	\$ * (767)

* 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	\$ 821,503	Tri Care Rehab	100.00%	\$ 762,966	\$ (58,537)
16	V						
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		\$ 821,503			\$ 762,966	\$ * (58,537)

* 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%	\$ 193,367	\$ 193,367	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	193,367	CCS Employee Benefits Group	100.00%		(193,367)	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		\$ 193,367			\$ 193,367	\$ *	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 Ancillary Expense	8,029	Care Centers Health Systems, Inc.	100.00%	8,029	\$	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		\$ 8,029			\$ 8,029	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10 Nursing Supplies / Nursing Equip. Rental	186	Reliable Medical of the Midwest, LLC	100.00%	134	\$	(52)	15
16	V	39 Ancillary Expense	2,875	Reliable Medical of the Midwest, LLC	100.00%	2,066		(809)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 3,061			\$ 2,200	\$ *	(861)	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 N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	B&Z GRANDCHILD TRUST	100%	BRIAR PLACE LTD.	INDIAN HEAD PARK	BEECHER PROPERTIES, LLC	EVANSTON	BUILDING CO.	1
2			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKEEP	2
3			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			GRASMERE PLACE, LLC	CHICAGO	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPLEN	4
5			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			MAJOR HOSPITAL DYER	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	7
8			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLY	8
9			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN	CARE CENTERS BUILDING LL	EVANSTON	BLDG COMPANY	9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				13
14			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			ST. JAMES WELLNESS REHAB VILLAS	CRETE				20
21			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				21
22			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				22
23			WHEATON CARE CENTER	WHEATON				23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$	1	
2										2	
3										3	
4										4	
5										5	
6										6	
7										7	
8										8	
9										9	
10										10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$	13	

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

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

Facility Name & ID Number Beecher Manor N & R Ctr

0047738 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 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

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	Patient Days	1,251,572	31	\$ 4,057	\$ 39,649	\$ 129	1
2	02	Food	Patient Days	1,251,572	31	18,150	39,649	575	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578	39,649	430	3
4	05	Utilities	Patient Days	1,251,572	31	30,626	39,649	970	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400	39,649	4,004	5
6	17	Administrative	Patient Days	1,251,572	31	84,000	39,649	2,661	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560	39,649	7,589	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626	39,649	1,414	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586	39,649	9,681	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989	39,649	221	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307	39,649	1,087	11
12	26	Insurance	Patient Days	1,251,572	31	36,877	39,649	1,168	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642	39,649	3,600	13
14	32	Interest	Patient Days	1,251,572	31	26,010	39,649	824	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240	39,649	2,098	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168	39,649	639	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,170,816	\$	\$ 37,090	25

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 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

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	06	Maintenance (Pooled)	Patient Days	1,251,572	31	217,811	217,811	39,649	6,900	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781		33,372	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		39,649	655	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212			3,822	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	39,649	14,388	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	39,649	84,424	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321		19,420	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		39,649	18,200	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282			3,039	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,662,721	\$ 3,975,053		\$ 184,220	25

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

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	03	Housekeeping	Patient Days	758,409	19	\$ 1,549	\$ 39,649	\$ 81	1
2	05	Utilities	Patient Days	758,409	19	2,849	39,649	149	2
3	06	Maintenance	Patient Days	758,409	19	2,348	39,649	123	3
4	19	Professional Fees	Patient Days	758,409	19	15,090	39,649	789	4
5	20	Dues and Subscriptions	Patient Days	758,409	19	4,042	39,649	211	5
6	21	Office & Clerical	Patient Days	758,409	19	23,285	39,649	1,217	6
7	24	Travel and Seminar	Patient Days	758,409	19	21,158	39,649	1,106	7
8	26	Insurance	Patient Days	758,409	19	8,431	39,649	441	8
9	30	Depreciation	Patient Days	758,409	19	19,889	39,649	1,040	9
10	32	Interest	Patient Days	758,409	19	563,670	39,649	29,468	10
11	33	Real Estate Taxes	Patient Days	758,409	19	7,558	39,649	395	11
12	01	Dietary Salary	Patient Days	758,409	19	75,731	75,731	3,959	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	758,409	19	8,645	39,649	452	13
14	10	Nursing Salary	Patient Days	758,409	19	697,742	697,742	36,477	14
15	12	Social Service Salary	Patient Days	758,409	19	316,078	316,078	16,524	15
16	15	Emp. Ben. - Healthcare	Patient Days	758,409	19	115,731	39,649	6,050	16
17	17	Administration Salary	Patient Days	758,409	19	1,104,097	1,104,097	57,721	17
18	21	Office Salary	Patient Days	758,409	19	427,044	427,044	22,325	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	758,409	19	174,785	39,649	9,138	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,589,719	\$ 2,620,691	\$ 187,666	25

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Vent Lease, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

1	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	Various Equipment	Direct Allocation					7,853	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				\$	\$		\$ 7,853	25

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 TriCare Rehab
 Street Address 240 Fencil Lane
 City / State / Zip Code Hillside, IL 60162
 Phone Number (773) 449-9400
 Fax Number (773) 449-9700

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	39	Therapy	Direct Allocation		\$	\$		\$ 762,966	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				\$	\$		\$ 762,966	25

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 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

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		\$	\$		\$ 193,367	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				\$	\$		\$ 193,367	25

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	39	Ancillary Expense	Direct Allocation					8,029	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				\$	\$		\$ 8,029	25

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

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	10	Nursing Supplies / Nursing Equip	Direct Allocation					134	1
2	39	Ancillary Expense	Direct Allocation					2,066	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				\$	\$		\$ 2,200	25

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	Name of Lender	2		3	4	5	6		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			\$	\$ 6,827,919			\$ 386,354	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	Central Illinois Bank		X	Line of Credit				400,000			12,219	6					
7	Dell		X					6,319				7					
8	See Supplemental Schedule										30,292	8					
9	TOTAL Facility Related						\$	\$ 7,234,237			\$ 428,865	9					
B. Non-Facility Related*																	
10	Interest Income		X								(33,117)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (33,117)	14					
15	TOTALS (line 9+line14)						\$	\$ 7,234,237			\$ 395,747	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

** 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 N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	Name of Lender	2		3	4	5	6		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							\$	\$			\$						
2																	
3																	
4																	
5																	
6																	
7	TOTAL Long-Term																
	Working Capital																
8	Allocated - Ext. Care Consultin	X					\$	\$			\$ 824						
9	Allocated - ext. Care Clinical	X									29,468						
10																	
11																	
12																	
13																	
14	TOTAL Working Capital										30,292						
	B. Non-Facility Related*																
15							\$	\$			\$						
16																	
17																	
18																	
19																	
20	TOTAL Non-Facility Related																

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**B. Real Estate Taxes**

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 report.				\$	164,983	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	166,239	2
3. Under or (over) accrual (line 2 minus line 1).				\$	1,256	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	171,933	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	173,189	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009	<u>130,233</u>	8	FOR BHF USE ONLY		
	2010	<u>135,013</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013	13
	2011	<u>145,006</u>	10	14	PLUS APPEAL COST FROM LINE 5	14
	2012	<u>157,126</u>	11	15	LESS REFUND FROM LINE 6	15
	2013	<u>163,746</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION	16
2014 Accrual = \$163,746 x 1.05 = \$171,933						
Allocated - Extended Care Consulting - \$2,098						
Allocated - Extended Care Clinical - \$395						

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beecher Manor N & R Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0047738

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>22-22-16-200-028-0000</u>	<u>Long Term Care Property</u>	\$ <u>159,872.92</u>	\$ <u>159,872.92</u>
2. <u>22-22-16-200-021-0000</u>	<u>Long Term Care Property</u>	\$ <u>3,873.16</u>	\$ <u>3,873.16</u>
3. <u>See Attached</u>	<u>Care Centers Building, LLC</u>	\$ <u>162,082.08</u>	\$ <u>2,374.88</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>325,828.16</u></u>	\$ <u><u>166,120.96</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Beecher Manor N & R Ctr

0047738 Report Period Beginning:

01/01/14 Ending:

12/31/14

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 - Care Centers Building / Extended Care Clinical</u>			<u>12,015</u>	<u>2</u>
3	TOTALS	123,116		\$ 175,733	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
130	2006	1985	\$ 2,546,584	\$ 65,297	39	\$ 65,297		\$ 579,510	4
		2008	1,794,872	46,021	39	46,022	1	293,415	5
		2009	3,618,157	92,770	39	93,675	905	548,770	6
		2010	4,953	126	39	122	(4)	610	7
									8
Improvement Type**									
Various		2006	44,583		20	2,229	2,229	18,715	9
Various		2007	35,433		20	1,641	1,641	15,484	10
Various		2008	107,367		20	4,911	4,911	45,881	11
Various		2009	113,868		20	1,539	1,539	91,527	12
Various		2010	20,272		20	1,483	1,483	6,556	13
									14
									15
									16
									17
									18
									19
									20
									21
									22
									23
									24
									25
									26
									27
									28
									29
									30
									31
									32
									33
									34
									35
									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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	<u>Related Building Company (Pages 12F & 12G)</u>								67
68	<u>Related Party Allocations (Pages 12H & 12I)</u>			52,508		3,315		36,330	68
69	<u>Financial Statement Depreciation</u>						(64,108)		69
70	TOTAL (lines 4 thru 69)			\$ 8,338,597		\$ 220,234	\$ (51,403)	\$ 1,636,798	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,338,597	\$ 271,637		\$ 220,234	\$ (51,403)	\$ 1,636,798	1
2	Painting	2011	3,519		20			3,519	2
3	Water Heater	2012	10,529		20	526	526	1,536	3
4	Air Conditioner	2012	17,400		20	870	870	2,175	4
5	Automatic Door	2012	6,475		20	324	324	971	5
6	Removal & Install New Call System - North End	2012	3,150		20	630	630	1,575	6
7	New Receiving Doors & Hardware	2012	2,959		20	148	148	394	7
8	Lobby Air Condition Rebuild	2012	4,281		20	214	214	571	8
9	New Blinds	2012	6,294		20	1,259	1,259	2,728	9
10	New Nurse Call System - South End	2012	5,620		20	1,124	1,124	2,342	10
11	Installation Of Drains, Vent And Sink In Dining Room	2013	8,500		20	850	850	1,558	11
12	Fence For Dumpster	2013	6,550		20	437	437	728	12
13	Cubicle Curtains	2013	16,444		20	1,644	1,644	2,467	13
14	Removed Trees, 2 Barns, 1 Corn Silo And Concrete Foundation	2013	23,200		20	1,160	1,160	1,547	14
15	Roof Work	2014	5,300		20	221	221	221	15
16	Installed New Relay For Compressor	2014	2,980		20	149	149	149	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)		\$ 8,461,799	\$ 271,637		\$ 229,790	\$ (41,847)	\$ 1,659,277	34

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

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,461,799	\$ 271,637		\$ 229,790	\$ (41,847)	\$ 1,659,277	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		\$ 8,461,799	\$ 271,637		\$ 229,790	\$ (41,847)	\$ 1,659,277	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,461,799	\$ 271,637		\$ 229,790	\$ (41,847)	\$ 1,659,277	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)		\$ 8,461,799	\$ 271,637		\$ 229,790	\$ (41,847)	\$ 1,659,277	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,461,799	\$ 271,637		\$ 229,790	\$ (41,847)	\$ 1,659,277	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)	\$ 8,461,799	\$ 271,637		\$ 229,790	\$ (41,847)	\$ 1,659,277	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward								
2	Buildings:								
3									
4									
5									
6									
7									
8	Leasehold Improvements								
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 (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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)	\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated - Care Centers Building, LLC	2002	13,933	357	35	357		4,391	3
4									4
5	Allocated - Extended Care Clinical, LLC	2002	2,624	67	35	67		827	5
6									6
7									7
8	Leasehold Information								8
9	Allocated - Extended Care Consulting, LLC	2007	146	7	20	7		58	9
10	Allocated - Extended Care Consulting, LLC	2009	87	4	20	4		26	10
11	Allocated - Extended Care Consulting, LLC	2010	855	43	20	43		214	11
12	Allocated - Extended Care Consulting, LLC	2011	308	15	20	15		62	12
13	Allocated - Extended Care Consulting, LLC	2012	101	5	20	5		15	13
14	Allocated - Extended Care Consulting, LLC	2014	1,405	70	20	70		70	14
15									15
16	Allocated - Care Centers Building, LLC	2002	11,510	981	20	981		11,510	16
17	Allocated - Care Centers Building, LLC	2003	13,564	1,156	20	1,156		13,564	17
18	Allocated - Care Centers Building, LLC	2005	674	72	20	72		601	18
19	Allocated - Care Centers Building, LLC	2009	122	6	20	6		36	19
20	Allocated - Care Centers Building, LLC	2014	1,942	97	20	97		97	20
21									21
22	Allocated - Extended Care Clinical, LLC	2002	2,167	185	20	185		2,167	22
23	Allocated - Extended Care Clinical, LLC	2003	2,554	218	20	218		2,554	23
24	Allocated - Extended Care Clinical, LLC	2005	127	13	20	13		113	24
25	Allocated - Extended Care Clinical, LLC	2009	23	1	20	1		7	25
26	Allocated - Extended Care Clinical, LLC	2014	366	18	20	18		18	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 52,508	\$ 3,315		\$ 3,315	\$	\$ 36,330	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 52,508	\$ 3,315		\$ 3,315	\$	\$ 36,330	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)		\$ 52,508	\$ 3,315		\$ 3,315	\$	\$ 36,330	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 160,269	\$ 390	\$ 19,905	\$ 19,515	10	\$ 113,215	71
72	Current Year Purchases	39,832	234	2,160	1,926	10	2,160	72
73	Fully Depreciated Assets	612,621				10	612,621	73
74								74
75	TOTALS	\$ 812,722	\$ 624	\$ 22,065	\$ 21,441		\$ 727,995	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. - Extended Care Consultin	2011	\$ 5,717	\$ 161	\$ 161		5	\$ 5,071	76
77		Alloc. - Extended Care Clinical	2012	2,686	537	537		5	1,331	77
78										78
79										79
80	TOTALS			\$ 8,403	\$ 698	\$ 698			\$ 6,402	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)	\$ 9,458,657	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 272,959	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 252,553	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,406)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,393,675	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.

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,141

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Beecher Manor N & R Ctr # 0047738 Report Period Beginning: 01/01/14 Ending: 12/31/14
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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	361,238	\$		\$	361,238	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				111,968				111,968	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				344,610				344,610	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					434,339			434,339	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						5,205	173,294			178,499	13
14	TOTAL			\$		\$	823,021	\$	607,633	\$	1,430,654	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.

Facility Name & ID Number Beecher Manor N & R Ctr # 0047738 Report Period Beginning: 01/01/14 Ending: 12/31/14
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	\$ 528,327	\$ 560,937	1
2	Cash-Patient Deposits	10,548	10,548	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,268,454	1,268,454	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	209,993	209,993	6
7	Other Prepaid Expenses	7,943	7,943	7
8	Accounts Receivable (owners or related parties)	2,792,134	2,566,262	8
9	Other(specify):	547,221	547,221	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,364,620	\$ 5,171,358	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		169,416	13
14	Buildings, at Historical Cost		7,964,566	14
15	Leasehold Improvements, at Historical Cost	404,786	404,786	15
16	Equipment, at Historical Cost	363,335	795,033	16
17	Accumulated Depreciation (book methods)	(490,904)	(2,341,298)	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):		44,523	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 277,217	\$ 7,037,026	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,641,837	\$ 12,208,384	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,173,602	\$ 1,173,602	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,554	15,554	28
29	Short-Term Notes Payable	406,319	406,319	29
30	Accrued Salaries Payable	286,860	286,860	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	171,933	171,933	32
33	Accrued Interest Payable		14,111	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,054,268	\$ 2,068,379	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,827,919	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,827,919	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,054,268	\$ 8,896,298	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,587,569	\$ 3,312,086	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,641,837	\$ 12,208,384	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,382,491	1
2	Restatements (describe):		2
3	Bad Debt / Accounts Receivable Adjustments	(66,072)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,316,419	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	631,150	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	(360,000)	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)	\$ 271,150	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,587,569	24 *

* This must agree with page 17, line 47.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,094,195	1
2	Discounts and Allowances for all Levels	(3,780,969)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,313,226	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,407,851	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,407,851	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	2,406	13
14	Non-Patient Meals	20	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	451,990	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,962	19
20	Radiology and X-Ray	19,654	20
21	Other Medical Services	(105,082)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 401,950	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	33,117	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,117	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,252	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,252	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,157,396	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,675,714	31
32	Health Care	3,390,893	32
33	General Administration	1,763,898	33
B. Capital Expense			
34	Ownership	994,525	34
C. Ancillary Expense			
35	Special Cost Centers	1,430,654	35
36	Provider Participation Fee	270,562	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,526,246	40
41	Income before Income Taxes (line 30 minus line 40)**	631,150	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 631,150	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,500,384	44
45	Private Pay - Net Inpatient Revenue	1,632,727	45
46	Medicare - Net Inpatient Revenue	713,041	46
47	Other-(specify) <u>Hospice</u>	457,354	47
48	Other-(specify) <u>Insurance</u>	9,720	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,313,226	49

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

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

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

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

Facility Name & ID Number Beecher Manor N & R Ctr

0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	1,857	2,120	\$ 95,556	\$ 45.07	1
2	Assistant Director of Nursing	1,884	2,112	74,554	35.30	2
3	Registered Nurses	22,807	25,180	768,331	30.51	3
4	Licensed Practical Nurses	23,266	25,969	666,578	25.67	4
5	CNAs & Orderlies	72,057	77,305	918,300	11.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,274	10,582	185,089	17.49	8
9	Activity Director	1,887	2,086	52,752	25.29	9
10	Activity Assistants	8,843	9,544	92,632	9.71	10
11	Social Service Workers	7,778	8,358	166,066	19.87	11
12	Dietician	1,299	1,319	23,739	18.00	12
13	Food Service Supervisor	1,868	2,118	63,063	29.77	13
14	Head Cook	4,046	4,683	55,394	11.83	14
15	Cook Helpers/Assistants	21,811	24,039	214,108	8.91	15
16	Dishwashers					16
17	Maintenance Workers	6,550	7,309	137,448	18.81	17
18	Housekeepers	18,034	19,382	192,622	9.94	18
19	Laundry					19
20	Administrator	1,978	2,111	78,952	37.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,373	6,955	80,075	11.51	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	1,767	2,097	37,823	18.04	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,022	2,317	38,096	16.44	33
34	TOTAL (lines 1 - 33)	215,401	235,586	\$ 3,941,178 *	\$ 16.73	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	469	\$ 23,826	01-03	35
36	Medical Director	Monthly	20,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,589	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					48
49	TOTAL (lines 35 - 48)	469	\$ 52,415		49

C. CONTRACT NURSES

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

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Beecher Manor N & R Ctr# 0047738

Report Period Beginning:

01/01/14

Ending:

12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$ 10,444
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 75,449 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. \$ 270,562
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 20
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.