

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

0047738 Report Period Beginning: 01/01/17 Ending: 12/31/17

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,712	3,510	18,481	39,703	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,712	3,510	18,481	39,703	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.67%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 10,950

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	368,114	67,612	37,584	473,310		473,310	7,989	481,299		1
2	Food Purchase		262,995		262,995		262,995	178	263,173		2
3	Housekeeping	210,348	54,473		264,821		264,821	995	265,816		3
4	Laundry	31,414	25,424	42,000	98,838		98,838		98,838		4
5	Heat and Other Utilities			147,592	147,592		147,592	1,220	148,812		5
6	Maintenance	133,144	43	272,352	405,539		405,539	9,708	415,247		6
7	Other (specify):*							9,314	9,314		7
8	TOTAL General Services	743,020	410,547	499,528	1,653,095		1,653,095	29,404	1,682,499		8
	B. Health Care and Programs										
9	Medical Director			18,047	18,047		18,047		18,047		9
10	Nursing and Medical Records	2,669,068	300,006	555,389	3,524,463		3,524,463	32,805	3,557,268		10
10a	Therapy	184,915		782	185,697		185,697		185,697		10a
11	Activities	149,432	24,061		173,493		173,493		173,493		11
12	Social Services	177,271			177,271		177,271	28,235	205,506		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*	68,816			68,816		68,816	8,907	77,723		15
16	TOTAL Health Care and Programs	3,249,502	324,067	574,218	4,147,787		4,147,787	69,947	4,217,734		16
	C. General Administration										
17	Administrative	95,702			95,702		95,702	84,501	180,203		17
18	Directors Fees										18
19	Professional Services			547,402	547,402		547,402	(431,886)	115,516		19
20	Dues, Fees, Subscriptions & Promotions			85,923	85,923		85,923	(29,144)	56,779		20
21	Clerical & General Office Expenses	94,710	61,767	547,536	704,013		704,013	(357,828)	346,185		21
22	Employee Benefits & Payroll Taxes			736,807	736,807		736,807	(21,194)	715,613		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,434	1,434		1,434	1,047	2,481		24
25	Other Admin. Staff Transportation			6,774	6,774		6,774	732	7,506		25
26	Insurance-Prop.Liab.Malpractice			158,984	158,984		158,984	1,844	160,828		26
27	Other (specify):*							34,428	34,428		27
28	TOTAL General Administration	190,412	61,767	2,084,860	2,337,039		2,337,039	(717,500)	1,619,539		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,182,934	796,381	3,158,606	8,137,921		8,137,921	(618,149)	7,519,772		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 Nursing & Rehab Center, Llc #0047738 Report Period Beginning: 01/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			64,426	64,426		64,426	198,885	263,311		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			1,447	1,447		1,447	287,001	288,448		32
33	Real Estate Taxes			181,358	181,358		181,358	3,713	185,071		33
34	Rent-Facility & Grounds			960,594	960,594		960,594	(960,000)	594		34
35	Rent-Equipment & Vehicles			1,255	1,255		1,255	809	2,064		35
36	Other (specify):*										36
37	TOTAL Ownership			1,209,080	1,209,080		1,209,080	(469,592)	739,488		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		459,566	1,436,273	1,895,839		1,895,839	(31,707)	1,864,132		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			247,652	247,652		247,652		247,652		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		459,566	1,683,925	2,143,491		2,143,491	(31,707)	2,111,784		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,182,934	1,255,947	6,051,611	11,490,492		11,490,492	(1,119,448)	10,371,044		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 Nursing & Rehab Center, Llc**

0047738

Report Period Beginning:

01/01/17

Ending:

12/31/17

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				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	(92,966)	30		9
10	Interest and Other Investment Income	(2,361)	32		10
11	Discounts, Allowances, Rebates & Refunds	(21)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(229)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(454,762)	21		24
25	Fund Raising, Advertising and Promotional	(21,829)	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	(30,687)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (602,855)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(516,593)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (516,593)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,119,448)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Beecher Manor Nursing & Rehab Center, Llc

ID# 0047738

Report Period Beginning: 01/01/17

Ending: 12/31/17

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Other Income	\$ (531)	21	1
2	Charitable Donations	(2,167)	20	2
3	Theft Loss	(1,626)	21	3
4	Collection Expense	(5,340)	21	4
5	Building Co - Bank Service Charges	(76)	21	5
6	PAC Dues	(6,038)	20	6
7	Chamber of Commerce Dues	(350)	20	7
8	Annual Report	(250)	20	8
9	Lobbying	(1,962)	21	9
10	Non Allowable Legal Fees	(906)	19	10
11	Building Co - Management Fee	(6,350)	21	11
12	Building Co - Filing Fee	(250)	21	12
13	Building Co - Amortization Expense	(4,841)	31	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(30,687)		49

Beecher Manor Nursing & Rehab Center, Llc

Report Period Beginning: 01/01/17
 Ending: 12/31/17

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

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/17

Ending:

12/31/17**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			147		7,842							7,989	1
2	Food Purchase	(250)		428									178	2
3	Housekeeping			885		110							995	3
4	Laundry													4
5	Heat and Other Utilities			1,096		124							1,220	5
6	Maintenance			3,018	6,476	214							9,708	6
7	Other (specify):*				8,216	1,098							9,314	7
8	TOTAL General Services	(250)		5,574	14,692	9,388							29,404	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					35,368		(2,563)					32,805	10
10a	Therapy													10a
11	Activities													11
12	Social Services					28,235							28,235	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,907							8,907	15
16	TOTAL Health Care and Programs					72,510		(2,563)					69,947	16
	C. General Administration													
17	Administrative			2,259	12,988	69,254							84,501	17
18	Directors Fees													18
19	Professional Services	(906)		(323,064)		(108,002)		86					(431,886)	19
20	Fees, Subscriptions & Promotions	(30,634)		656		834							(29,144)	20
21	Clerical & General Office Expenses	(470,897)	6,676	6,490	81,233	18,670							(357,828)	21
22	Employee Benefits & Payroll Taxes				(21,194)								(21,194)	22
23	Inservice Training & Education													23
24	Travel and Seminar			28		1,019							1,047	24
25	Other Admin. Staff Transportation			732									732	25
26	Insurance-Prop.Liab.Malpractice			1,321		523							1,844	26
27	Other (specify):*				22,310	12,118							34,428	27
28	TOTAL General Administration	(502,437)	6,676	(311,578)	95,337	(5,584)		86					(717,500)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(502,687)	6,676	(306,004)	110,029	76,314		(2,477)					(618,149)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/17

Ending:

12/31/17

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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(92,966)	289,601	1,879		371							198,885	30
31	Amortization of Pre-Op. & Org.	(4,841)	4,841											31
32	Interest	(2,361)	277,462	11,765		135							287,001	32
33	Real Estate Taxes			3,301		412							3,713	33
34	Rent-Facility & Grounds		(960,000)										(960,000)	34
35	Rent-Equipment & Vehicles			809									809	35
36	Other (specify):*													36
37	TOTAL Ownership	(100,168)	(388,096)	17,754		918							(469,592)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(31,707)					(31,707)	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							(31,707)					(31,707)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(602,855)	(381,420)	(288,250)	110,029	77,232		(34,184)					(1,119,448)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 960,000	Beecher Properties, LLC	100.00%	\$	(960,000)	1
2	V	21 Management Fee		Beecher Properties, LLC	100.00%	6,350	6,350	2
3	V	21 Filing Fee		Beecher Properties, LLC	100.00%	250	250	3
4	V	30 Depreciation Expense		Beecher Properties, LLC	100.00%	289,601	289,601	4
5	V	31 Amortization Expense		Beecher Properties, LLC	100.00%	4,841	4,841	5
6	V	32 Interest Expense		Beecher Properties, LLC	100.00%	277,462	277,462	6
7	V	21 Bank Service Charges		Beecher Properties, LLC	100.00%	76	76	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 960,000			\$ 578,580	\$ * (381,420)	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%	\$ 147	\$ 147
16	V	02 Food		Extended Care Consulting, LLC	100.00%	428	428
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	885	885
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,096	1,096
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	3,018	3,018
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,259	2,259
21	V	19 Professional Fees	325,968	Extended Care Consulting, LLC	100.00%	2,904	(323,064)
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	656	656
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	6,490	6,490
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	28	28
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	732	732
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,321	1,321
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	1,879	1,879
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	11,765	11,765
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,301	3,301
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	809	809
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 325,968			\$ 37,718	\$ * (288,250)

* 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%	6,476	\$	6,476	15
16	V	06 Maintenance (Direct)	39,637	Extended Care Consulting, LLC	100.00%	39,637			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	600		600	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	7,616		7,616	18
19	V								19
20	V								20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	12,988		12,988	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	81,233		81,233	22
23	V	21 Office and Clerical (Direct)	31,011	Extended Care Consulting, LLC	100.00%	31,011			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	18,205		18,205	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,105		4,105	25
26	V	22 Employee Benefits	21,194	Extended Care Consulting, LLC	100.00%			(21,194)	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		\$ 91,842			\$ 201,871	\$ *	110,029	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 110	\$	110	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	124		124	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	214		214	17
18	V	19 Professional Fees	108,660	Extended Care Clinical, LLC	100.00%	658		(108,002)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	834		834	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,387		1,387	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,019		1,019	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	523		523	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	371		371	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	135		135	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	412		412	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	7,842		7,842	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,098		1,098	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	35,368		35,368	28
29	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	28,235		28,235	29
30	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	8,907		8,907	30
31	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	69,254		69,254	31
32	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	17,283		17,283	32
33	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	12,118		12,118	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 108,660			\$ 185,892	\$ *	77,232	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 Various Equipment	2,720	Vent Lease LLC	100.00%	2,720	\$	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		\$ 2,720			\$ 2,720	\$ *	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	\$	MAC Rx, LLC	100.00%	\$		15
16	V	10 Nursing and Medical Records	31,023	MAC Rx, LLC	100.00%	28,460	(2,563)	16
17	V	10A Therapy		MAC Rx, LLC	100.00%			17
18	V	19 Professional Services	(1,037)	MAC Rx, LLC	100.00%	(951)	86	18
19	V	21 Clerical & General Office Expenses		MAC Rx, LLC	100.00%			19
20	V	22 Employee Benefits		MAC Rx, LLC	100.00%			20
21	V	39 Ancillary	383,862	MAC Rx, LLC	100.00%	352,155	(31,707)	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		\$ 413,849			\$ 379,665	\$ * (34,184)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 285,547	\$ 285,547	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	285,547	CCS Employee Benefits Group	100.00%		(285,547)	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		\$ 285,547			\$ 285,547	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, LI # 0047738 Report Period Beginning: 01/01/17 Ending: 12/31/17

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										11
12										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 Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

0047738

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,476,506	37	\$ 5,451	\$ 39,703	\$ 147	1
2	02	Food	Patient Days	1,476,506	37	15,903	39,703	428	2
3	03	Housekeeping	Patient Days	1,476,506	37	32,901	39,703	885	3
4	05	Utilities	Patient Days	1,476,506	37	40,755	39,703	1,096	4
5	06	Maintenance	Patient Days	1,476,506	37	112,249	39,703	3,018	5
6	17	Administrative	Patient Days	1,476,506	37	84,000	39,703	2,259	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994	39,703	2,904	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409	39,703	656	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371	39,703	6,490	9
10	24	Seminar and Travel	Patient Days	1,476,506	37	1,048	39,703	28	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239	39,703	732	11
12	26	Insurance	Patient Days	1,476,506	37	49,139	39,703	1,321	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861	39,703	1,879	13
14	32	Interest	Patient Days	1,476,506	37	437,528	39,703	11,765	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769	39,703	3,301	15
16	35	Rent - Equipment & Auto	Patient Days	1,476,506	37	30,092	39,703	809	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,402,709	\$	\$ 37,718	25

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

0047738

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,476,506	37	240,841	240,841	39,703	6,476	1
2	06	Maintenance (Direct)	Direct		21	358,056	358,056		39,637	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,476,506	37	22,330		39,703	600	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		21	51,193			7,616	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,476,506	37	483,002	483,002	39,703	12,988	7
8	21	Office and Clerical (Pooled)	Patient Days	1,476,506	37	3,020,951	3,020,951	39,703	81,233	8
9	21	Office and Clerical (Direct)	Direct		28	498,631	498,631		31,011	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,476,506	37	677,040		39,703	18,205	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	74,203			4,105	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,426,248	\$ 4,601,481		\$ 201,871	25

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

0047738

Report Period Beginning:

01/01/17

Ending: 12/31/17

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	781,509	20	\$ 2,174	\$ 39,703	\$ 110	1
2	05	Utilities	Patient Days	781,509	20	2,440	39,703	124	2
3	06	Maintenance	Patient Days	781,509	20	4,212	39,703	214	3
4	19	Professional Fees	Patient Days	781,509	20	12,959	39,703	658	4
5	20	Dues and Subscriptions	Patient Days	781,509	20	16,422	39,703	834	5
6	21	Office & Clerical	Patient Days	781,509	20	27,302	39,703	1,387	6
7	24	Travel and Seminar	Patient Days	781,509	20	20,068	39,703	1,019	7
8	26	Insurance	Patient Days	781,509	20	10,303	39,703	523	8
9	30	Depreciation	Patient Days	781,509	20	7,302	39,703	371	9
10	32	Interest	Patient Days	781,509	20	2,656	39,703	135	10
11	33	Real Estate Taxes	Patient Days	781,509	20	8,112	39,703	412	11
12	01	Dietary Salary	Patient Days	781,509	20	154,359	39,703	7,842	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	781,509	20	21,616	39,703	1,098	13
14	10	Nursing Salary	Patient Days	781,509	20	696,174	39,703	35,368	14
15	12	Social Service Salary	Patient Days	781,509	20	555,767	39,703	28,235	15
16	15	Emp. Ben. - Healthcare	Patient Days	781,509	20	175,320	39,703	8,907	16
17	17	Administration Salary	Patient Days	781,509	20	1,363,182	39,703	69,254	17
18	21	Office Salary	Patient Days	781,509	20	340,193	39,703	17,283	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	781,509	20	238,538	39,703	12,118	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,659,098	\$ 3,109,674	\$ 185,892	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	10	Various Equipment	Direct Allocation					2,720	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				\$	\$		\$ 2,720	25

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

0047738

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

MAC Rx, LLC

Street Address

2307 S. Mount Prospect Road

City / State / Zip Code

Des Plaines, IL 60018

Phone Number

(224)220-2700

Fax Number

(224)220-2730

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance	Direct Allocation		\$	\$		\$	1
2	10	Nursing And Medical Records	Direct Allocation					28,460	2
3	10A	Therapy	Direct Allocation						3
4	19	Professional Services	Direct Allocation					(951)	4
5	21	Clerical & General Office Expense	Direct Allocation						5
6	22	Employee Benefits	Direct Allocation						6
7	39	Ancillary	Direct Allocation					352,155	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				\$	\$		\$ 379,665	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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		\$	\$		\$ 285,547	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				\$	\$		\$ 285,547	25

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

0047738

Report Period Beginning:

01/01/17

Ending: **12/31/17**

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 Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Beecher Manor Nursing & Rehab Center, Llc # 0047738 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	CIBM Bank		X	Mortgage			\$	\$ 11,354,531		\$ 277,462	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	CIB Bank		X	Line of Credit				688,666		1,447	6									
7	Alliance Laundry Systems		X	Note Payable				27,164			7									
8	See Supplemental Schedule									11,900	8									
9	TOTAL Facility Related						\$	\$ 12,070,361		\$ 290,809	9									
B. Non-Facility Related*																				
10	Interest Income		X							(2,361)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (2,361)	14									
15	TOTALS (line 9+line14)						\$	\$ 12,070,361		\$ 288,448	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.)

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 2016 report.		\$	187,129	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.)		\$	183,463	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,666)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	188,737	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.		\$	185,071	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	157,126	8
	2013	163,746	9
	2014	171,788	10
	2015	178,218	11
	2016	179,750	12

2017 Accrual = \$179,750 x 1.05 = \$188,737

Allocated from Extended Care Consulting = \$3,301

Allocated from Extended Care Clinical = \$412

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

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

0047738 Report Period Beginning:

01/01/17 Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>123,116</u>	<u>2006</u>	<u>\$ 163,718</u>	<u>1</u>
2	<u>Allocated from Care Center Building</u>			<u>16,819</u>	<u>2</u>
3	TOTALS	123,116		\$ 180,537	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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	130	2006	1985	\$ 2,546,584	\$	39	\$ 65,297	\$ 65,297	\$ 775,401	4
5			2008	1,794,872		39	46,022	46,022	431,481	5
6			2009	3,618,157		39	92,773	92,773	828,893	6
7			2010	4,953		39	127	127	981	7
8					289,601			(289,601)		8
Improvement Type**										
9	Various		2006	44,583		20	2,229	2,229	25,403	9
10	Various		2007	35,433		20	1,641	1,641	20,407	10
11	Various		2008	107,367		20	4,911	4,911	60,615	11
12	Various		2009	113,868		20	1,539	1,539	96,145	12
13	Various		2010	20,272		20	857	857	9,596	13
14	Various		2011	3,519		20			3,519	14
15	Various		2012	56,708		20	4,477	4,477	26,958	15
16	Various		2013	54,694		20	4,091	4,091	18,573	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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								67
68		82,257	1,225		1,225		55,126	68
69			64,426			(64,426)		69
70		\$ 8,483,267	\$ 355,252		\$ 225,190	\$ (130,062)	\$ 2,353,098	70

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

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

0047738

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,483,267	\$ 355,252		\$ 225,190	\$ (130,062)	\$ 2,353,098	1
2	Roof Work	2014	5,300		20	265	265	1,016	2
3	Installed New Relay For Compressor	2014	2,980		20	149	149	497	3
4	South Corridor Hvac	2015	29,612		20	1,481	1,481	3,948	4
5	Replace Faulty Sprinkler Valve	2015	3,710		20	186	186	464	5
6	2 White Sinks	2017	8,990		20	450	450	450	6
7	Wireless Access Points	2017	15,480		20	1,548	1,548	1,548	7
8	Faux Stucco Exterior Sign With Light Fixtures	2017	22,364		20	621	621	621	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)		\$ 8,571,703	\$ 355,252		\$ 229,889	\$ (125,363)	\$ 2,361,641	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		\$ 8,571,703	\$ 355,252		\$ 229,889	\$ (125,363)	\$ 2,361,641	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		\$ 8,571,703	\$ 355,252		\$ 229,889	\$ (125,363)	\$ 2,361,641	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		\$ 8,571,703	\$ 355,252		\$ 229,889	\$ (125,363)	\$ 2,361,641	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		\$ 8,571,703	\$ 355,252		\$ 229,889	\$ (125,363)	\$ 2,361,641	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		\$ 8,571,703	\$ 355,252		\$ 229,889	\$ (125,363)	\$ 2,361,641	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)	\$ 8,571,703	\$ 355,252		\$ 229,889	\$ (125,363)	\$ 2,361,641	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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

0047738

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated - Extended Care Consulting-Care Center Bldg	2002	20,605	528	35	528		8,079	3
4	Allocated - Extended Care Consulting, LLC - Dyer Building	2007	6,454	143	35	143		1,501	4
5	Allocated from Extended Care Clinical-Care Center Bldg	2002	2,572	66	35	66		1,009	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	124	6	20	6		68	9
10	Allocated from Extended Care Consulting	2009	74	4	20	4		33	10
11	Allocated from Extended Care Consulting	2010	725	36	20	36		290	11
12	Allocated from Extended Care Consulting	2011	261	13	20	13		91	12
13	Allocated from Extended Care Consulting	2012	86	4	20	4		26	13
14	Allocated from Extended Care Consulting	2014	1,193	60	20	60		239	14
15	Allocated from Extended Care Consulting	2016	1,430	71	20	71		143	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2002	17,022		20			17,022	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2003	20,059		20			20,059	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2005	997		20			997	18
19	Allocated from Extended Care Consulting-Care Center Bldg	2009	180	9	20	9		81	19
20	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,726	86	20	86		345	20
21	Allocated from Extended Care Consulting-Care Center Bldg	2015	284	14	20	14		92	21
22	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,120	56	20	56		112	22
23	Allocated from Extended Care Consulting-Care Center Bldg	2017	1,943	97	20	97		97	23
24									24
25	Allocated from Extended Care Clinical-Care Center Bldg	2002	2,125		20			2,125	25
26	Allocated from Extended Care Clinical-Care Center Bldg	2003	2,504		20			2,504	26
27	Allocated from Extended Care Clinical-Care Center Bldg	2005	124		20			124	27
28	Allocated from Extended Care Clinical-Care Center Bldg	2009	22	1	20	1		10	28
29	Allocated from Extended Care Clinical-Care Center Bldg	2014	209	10	20	10		42	29
30	Allocated from Extended Care Clinical-Care Center Bldg	2015	35	2	20	2		11	30
31	Allocated from Extended Care Clinical-Care Center Bldg	2016	140	7	20	7		14	31
32	Allocated from Extended Care Clinical-Care Center Bldg	2017	243	12	20	12		12	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 82,257	\$ 1,225		\$ 1,225	\$	\$ 55,126	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		\$ 82,257	\$ 1,225		\$ 1,225		\$ 55,126	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)	\$ 82,257	\$ 1,225		\$ 1,225		\$ 55,126	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	\$ 118,134	\$ 613	\$ 17,835	\$ 17,222	10	\$ 70,746	71
72	Current Year Purchases	112,781		15,175	15,175	10	15,175	72
73	Fully Depreciated Assets	707,402				10	707,402	73
74								74
75	TOTALS	\$ 938,317	\$ 613	\$ 33,010	\$ 32,397		\$ 793,323	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care Consulting, LLC		\$ 4,853	\$ 137	\$ 137		5	\$ 4,716	76
77		Allocated from Extended Care Clinical, LLC		2,610	273	273		5	2,610	77
78										78
79										79
80	TOTALS			\$ 7,463	\$ 410	\$ 410			\$ 7,326	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)	\$ 9,698,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 356,275	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 263,309	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (92,966)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,162,290	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 7,632,017	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 Nursing & Rehab Center, Llc

0047738

Report Period Beginning: 01/01/17

Ending: 12/31/17

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	Storage Rental				594			5
6								6
7	TOTAL				\$ 594			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. _____ /2018 \$ _____

13. _____ /2019 \$ _____

14. _____ /2020 \$ _____

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: \$ 2,064 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 658,268	\$		\$ 658,268	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			98,145			98,145	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			669,319			669,319	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				245,108		245,108	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					10,541	214,458		224,999	13
14	TOTAL			\$		\$ 1,436,273	\$ 459,566		\$ 1,895,839	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 Nursing & Rehab Center, Llc

0047738

Report Period Beginning: 01/01/17

Ending:

12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 825,003	\$ 850,244	1
2	Cash-Patient Deposits	23,413	23,413	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,280,867	1,280,867	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,856	95,856	6
7	Other Prepaid Expenses	8,295	8,295	7
8	Accounts Receivable (owners or related parties)	3,286,634	1,597,968	8
9	Other(specify): <u>See Attached Schedule</u>	568,533	568,533	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,088,601	\$ 4,425,176	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		163,718	13
14	Buildings, at Historical Cost		7,994,881	14
15	Leasehold Improvements, at Historical Cost	465,753	465,753	15
16	Equipment, at Historical Cost	450,167	881,865	16
17	Accumulated Depreciation (book methods)	(670,362)	(3,982,569)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	124,411	7,712,705	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 369,969	\$ 13,236,353	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,458,570	\$ 17,661,529	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 583,619	\$ 583,617	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,591	18,591	28
29	Short-Term Notes Payable	715,830	715,830	29
30	Accrued Salaries Payable	162,843	162,843	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,181	7,181	31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,737	188,737	32
33	Accrued Interest Payable		11,748	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	447	447	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,677,248	\$ 1,688,994	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,354,531	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)	\$	\$ 11,354,531	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,677,248	\$ 13,043,525	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,781,322	\$ 4,618,004	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,458,570	\$ 17,661,529	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,988,265	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,988,265	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,153,057	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)	\$ 793,057	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)	\$ 4,781,322	24 *

* This must agree with page 17, line 47.

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

0047738

Report Period Beginning: 01/01/17

Ending:

12/31/17

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		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,336,145	1
2	Discounts and Allowances for all Levels	(6,404,888)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,931,257	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,020,960	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,020,960	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,327	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	385,415	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	81,041	19
20	Radiology and X-Ray	31,984	20
21	Other Medical Services	188,652	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 688,419	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,361	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,361	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	552	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 552	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,643,549	30

1		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,653,095	31
32	Health Care	4,147,787	32
33	General Administration	2,337,039	33
B. Capital Expense			
34	Ownership	1,209,080	34
C. Ancillary Expense			
35	Special Cost Centers	1,895,839	35
36	Provider Participation Fee	247,652	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,490,492	40
41	Income before Income Taxes (line 30 minus line 40)**	1,153,057	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,153,057	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,963,194	44
45	Private Pay - Net Inpatient Revenue	1,295,190	45
46	Medicare - Net Inpatient Revenue	784,657	46
47	Other-(specify) <u>Hospice</u>	818,899	47
48	Other-(specify) <u>Insurance</u>	69,317	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,931,257	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 Nursing & Rehab Center, Llc

0047738

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	1,825	2,129	\$ 109,242	\$ 51.32	1
2	Assistant Director of Nursing	1,926	2,315	90,097	38.92	2
3	Registered Nurses	22,833	24,961	834,732	33.44	3
4	Licensed Practical Nurses	23,086	25,800	768,903	29.80	4
5	CNAs & Orderlies	50,835	55,501	785,218	14.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,959	9,239	184,915	20.01	8
9	Activity Director	1,903	2,162	57,826	26.75	9
10	Activity Assistants	7,930	8,139	91,606	11.26	10
11	Social Service Workers	6,054	6,719	177,271	26.38	11
12	Dietician					12
13	Food Service Supervisor	3,246	3,617	95,830	26.49	13
14	Head Cook	7,667	8,326	106,653	12.81	14
15	Cook Helpers/Assistants	15,903	18,257	165,631	9.07	15
16	Dishwashers					16
17	Maintenance Workers	7,010	7,676	133,144	17.35	17
18	Housekeepers	17,994	18,741	210,348	11.22	18
19	Laundry	2,923	3,274	31,414	9.60	19
20	Administrator	1,901	2,096	95,702	45.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,990	7,633	94,710	12.41	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	1,856	2,084	36,185	17.37	31
32	Other Health Care(specify)					32
33	Other(specify)	8,682	9,545	113,507	11.89	33
34	TOTAL (lines 1 - 33)	198,522	218,213	\$ 4,182,934 *	\$ 19.17	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	727	\$ 37,584	01-03	35
36	Medical Director	Monthly	18,047	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,563	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	15	782	10a-03	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)	742	\$ 64,976		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	430	\$ 25,148	10-03	50
51	Licensed Practical Nurses	206	9,373	10-03	51
52	Certified Nurse Assistants/Aides	20,492	512,305	10-03	52
53	TOTAL (lines 50 - 52)	21,128	\$ 546,826		53

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

0047738

Report Period Beginning: **01/01/17**

Ending: **12/31/17**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Michael Stoudt	Administrator	0	\$ 95,702	Workers' Compensation Insurance	\$ 151,217	IDPH License Fee	\$ 1,990			
				Unemployment Compensation Insurance	49,161	Advertising: Employee Recruitment	24,213			
				FICA Taxes	310,332	Health Care Worker Background Check	4,557			
				Employee Health Insurance	194,740	(Indicate # of checks performed <u>276</u>)				
				Employee Meals		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	16,167			
				Employee Physicals	200	Licenses & Permits	8,362			
				Other Employee Benefits	9,963	Allocated from Extended Care Clinical	834			
						Allocated from Extended Care Consulting	656			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 95,702							
(List each licensed administrator separately.)										
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
			\$			\$	Out-of-State Travel	\$		
							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 715,613	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 56,779
(Attach a copy of any management service agreement)										
C. Professional Services										
Vendor/Payee	Type		Amount							
Marcum LLP	Accounting		\$ 25,107							
Blymas	Tax Credit Services		2,140							
Pinnacle Quality Insight	Customer Satisfaction		2,535							
SB2 Inc	MCD Reimb Consulting		999							
Benefit Service Group	Benefits Consulting		618							
Legat Architects	Architect Services		3,604							
ECC Clinical	Home Office Expense		108,660							
ECC Consulting	Home Office Expense		349,968				Seminar Expense	1,434		
Personnel Planners	Unemployment Consulting		1,440				Allocated from Extended Care Consulting	28		
ProPay	Payroll Services		24,006				Allocated from Extended Care Clinical	1,019		
Ability Network	Medicare Billing Services		6,196							
See Supplemental Schedule			22,129				Entertainment Expense	()		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 547,402	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2,481
(For legal fee disclosure, see page 39 of instructions)										

* Attach copy of IMRF notifications

**See instructions.

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 - \$12,077
- (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. \$ 71,698 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. \$ 247,652
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
 - 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