		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0047738

Facility Name: Beecher Manor Nrsg Rehab Ctr

Address: 1201 Dixie Highway (Number) Beecher (City) 60401 (Zip Code)

County: Will

Telephone Number: (708)946-2600 **Fax #** (708)946-9411

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2006

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
* *Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	130	Skilled (SNF)	130	47,580	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	47,580	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,403	3,943	13,163	35,509	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,403	3,943	13,163	35,509	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.63%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 2/1/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 128 and days of care provided 6,997

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	422,354	83,253	29,047	534,654		534,654	628	535,282			1
2	Food Purchase		287,172		287,172		287,172	(457)	286,715			2
3	Housekeeping	204,981	74,028		279,009		279,009	1,151	280,160			3
4	Laundry	63,176	50,945		114,121		114,121		114,121			4
5	Heat and Other Utilities			147,780	147,780		147,780	(15,347)	132,433			5
6	Maintenance	122,568	72	280,600	403,240		403,240	(62,997)	340,243			6
7	Other (specify):*							3,132	3,132			7
8	TOTAL General Services	813,079	495,470	457,427	1,765,976		1,765,976	(73,890)	1,692,086			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,876,654	406,353	716,215	3,999,222		3,999,222	12,312	4,011,534			10
10a	Therapy	62,275		1,877	64,152		64,152		64,152			10a
11	Activities	129,183	25,304		154,487		154,487		154,487			11
12	Social Services	209,496			209,496		209,496	13,423	222,919			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	31,163			31,163		31,163	6,230	37,393			15
16	TOTAL Health Care and Programs	3,308,771	431,657	736,092	4,476,520		4,476,520	31,965	4,508,485			16
	C. General Administration											
17	Administrative							100,013	100,013			17
18	Directors Fees											18
19	Professional Services			539,463	539,463	(13)	539,450	(446,056)	93,395			19
20	Dues, Fees, Subscriptions & Promotions			178,339	178,339		178,339	(13,916)	164,423			20
21	Clerical & General Office Expenses	210,630	48,144	343,575	602,349		602,349	(131,398)	470,951			21
22	Employee Benefits & Payroll Taxes			723,577	723,577		723,577	(18,602)	704,975			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,127	1,127		1,127	645	1,772			24
25	Other Admin. Staff Transportation			3,082	3,082		3,082	582	3,664			25
26	Insurance-Prop.Liab.Malpractice			305,844	305,844		305,844	1,593	307,437			26
27	Other (specify):*							40,208	40,208			27
28	TOTAL General Administration	210,630	48,144	2,095,007	2,353,781	(13)	2,353,768	(466,931)	1,886,837			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,332,480	975,271	3,288,526	8,596,277	(13)	8,596,264	(508,856)	8,087,408			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 Nrsg Rehab Ctr #0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			62,213	62,213		62,213	590,847	653,060			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,122	10,122		10,122	540,590	550,712			32
33	Real Estate Taxes			298,564	298,564	13	298,577	4,412	302,989			33
34	Rent-Facility & Grounds			1,080,000	1,080,000		1,080,000	(1,080,000)				34
35	Rent-Equipment & Vehicles			2,232	2,232		2,232	213	2,445			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,453,131	1,453,131	13	1,453,144	56,062	1,509,206			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		337,402	843,318	1,180,720		1,180,720	(24,558)	1,156,162			39
40	Barber and Beauty Shops			616	616		616		616			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			268,155	268,155		268,155		268,155			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		337,402	1,112,089	1,449,491		1,449,491	(24,558)	1,424,933			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,332,480	1,312,673	5,853,746	11,498,899		11,498,899	(477,352)	11,021,547			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 Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(228)	02		4
5	Telephone, TV & Radio in Resident Rooms	(16,591)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(142,580)	30		9
10	Interest and Other Investment Income	(7,496)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(314)	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	(450)	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	(250,794)	21		24
25	Fund Raising, Advertising and Promotional	(9,158)	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	(77,241)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (504,852)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	27,499		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 27,499		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (477,353)		37

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

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

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

Beecher Manor Nrsg Rehab Ctr

ID# 0047738

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (885)	21	1
2	Theft Loss	(17,950)	21	2
3	Collection Expense	(5,803)	21	3
4	Bldg Co - Management Fee	(6,350)	21	4
5	Bldg Co - Filing Fee	(75)	21	5
6	Bldg Co - Amortization	(3,301)	36	6
7	Capitalized R&M	(30,274)	06	7
8	Non-Allowable Legal	(2,302)	19	8
9	Chamber of Commerce	(75)	20	9
10	PAC Dues	(7,106)	20	10
11	Duplicated Expense	(3,120)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(77,241)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Beecher Manor Nrsg Rehab Ctr

IDF 0047738

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		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

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			116	512								628	1
2	Food Purchase	(542)		85									(457)	2
3	Housekeeping			1,015	136								1,151	3
4	Laundry													4
5	Heat and Other Utilities	(16,591)		1,111	133								(15,347)	5
6	Maintenance	(30,274)		(32,857)	134								(62,997)	6
7	Other (specify):*			3,057	75								3,132	7
8	**TOTAL General Services**	(47,407)		(27,473)	990								(73,890)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				29,720	(14,532)	(2,876)						12,312	10
10a	Therapy													10a
11	Activities													11
12	Social Services				13,423								13,423	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,230								6,230	15
16	**TOTAL Health Care and Programs**				49,373	(14,532)	(2,876)						31,965	16
	C. General Administration													
17	Administrative			14,530	85,483								100,013	17
18	Directors Fees													18
19	Professional Services	(2,302)		(339,421)	(104,333)								(446,056)	19
20	Fees, Subscriptions & Promotions	(16,789)		1,892	981								(13,916)	20
21	Clerical & General Office Expenses	(284,977)	6,425	102,512	44,642								(131,398)	21
22	Employee Benefits & Payroll Taxes			(18,602)									(18,602)	22
23	Inservice Training & Education													23
24	Travel and Seminar			309	336								645	24
25	Other Admin. Staff Transportation			582									582	25
26	Insurance-Prop.Liab.Malpractice			1,247	346								1,593	26
27	Other (specify):*			21,384	18,824								40,208	27
28	**TOTAL General Administration**	(304,068)	6,425	(215,567)	46,279								(466,931)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(351,475)	6,425	(243,040)	96,642	(14,532)	(2,876)						(508,856)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(142,580)	731,347	1,956	124								590,847	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,496)	540,981	6,992	113								540,590	32
33	Real Estate Taxes			3,892	520								4,412	33
34	Rent-Facility & Grounds		(1,080,000)										(1,080,000)	34
35	Rent-Equipment & Vehicles			213									213	35
36	Other (specify):*	(3,301)	3,301											36
37	**TOTAL Ownership**	(153,377)	195,629	13,053	757								56,062	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(24,558)						(24,558)	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**						(24,558)						(24,558)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(504,852)	202,054	(229,987)	97,399	(14,532)	(27,434)						(477,352)	45

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] YES [ ] NO

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

1 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	Rent	$ 1,080,000	Beecher Properties, LLC		$	$ (1,080,000)	1
2	V	33	Real Estate Taxes	298,563	Beecher Properties, LLC		298,563		2
3	V	21	Management Fee		Beecher Properties, LLC		6,350	6,350	3
4	V	21	Filing Fee		Beecher Properties, LLC		75	75	4
5	V	30	Depreciation		Beecher Properties, LLC		731,347	731,347	5
6	V	36	Amortization		Beecher Properties, LLC		3,301	3,301	6
7	V	32	Interest		Beecher Properties, LLC		540,981	540,981	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,378,563			$ 1,580,618	$ * 202,054	14

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	B&Z GRANDCHILD TRUST	100.00%	BURBANK REHABILITATION CENTER	BURBANK	BEECHER PROPERTIES, LLC	EVANSTON	BUILDING COMPANY	1
2			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CONSULTIN	EVANSTON	MGMT/BOOKKEEPING	2
3			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			GRASMERE PLACE, LLC	CHICAGO	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL DYER	DYER, IN				8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				13
14			MCKINLEY HEALTH CARE CENTER	CANTON, OH				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	01	Dietary	$	Extended Care Consulting, LLC		$ 116	$ 116	15
16	V	02	Food		Extended Care Consulting, LLC		85	85	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,015	1,015	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,111	1,111	18
19	V	06	Maintenance		Extended Care Consulting, LLC		2,213	2,213	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	343,944	Extended Care Consulting, LLC		4,523	(339,421)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		1,892	1,892	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		9,962	9,962	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		309	309	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		582	582	25
26	V	26	Insurance		Extended Care Consulting, LLC		1,247	1,247	26
27	V	30	Depreciation		Extended Care Consulting, LLC		1,956	1,956	27
28	V	32	Interest		Extended Care Consulting, LLC		6,992	6,992	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		3,892	3,892	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		213	213	30
31	V	06	Maintenance Salaries	51,831	Extended Care Consulting, LLC		16,761	(35,070)	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		3,057	3,057	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		14,530	14,530	33
34	V	21	Office and Clerical Salaries	10,176	Extended Care Consulting, LLC		102,726	92,550	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		21,384	21,384	35
36	V	22	Employee Benefits	18,602	Extended Care Consulting, LLC			(18,602)	36
37	V								37
38	V								38
39	Total			$ 424,553			$ 194,566	$ * (229,987)	39

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	1	Dietary Salary	$	Extended Care Clinical, LLC		$ 512	$ 512	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		136	136	16
17	V	5	Utilities		Extended Care Clinical, LLC		133	133	17
18	V	6	Maintenance		Extended Care Clinical, LLC		134	134	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		75	75	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		28,970	28,970	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		750	750	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		13,423	13,423	22
23	V	15	Emp. Ben, - Direct Alloc.		Extended Care Clinical, LLC				23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		6,230	6,230	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		85,483	85,483	25
26	V	19	Professional Fees	108,660	Extended Care Clinical, LLC		1,187	(107,473)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC		3,140	3,140	27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		981	981	28
29	V	21	Office Salary		Extended Care Clinical, LLC		42,601	42,601	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		2,041	2,041	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		336	336	31
32	V	26	Insurance		Extended Care Clinical, LLC		346	346	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		18,824	18,824	33
34	V	30	Depreciation		Extended Care Clinical, LLC		124	124	34
35	V	32	Interest		Extended Care Clinical, LLC		113	113	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		520	520	36
37	V								37
38	V								38
39	Total			$ 108,660			$ 206,059	$ * 97,399	39

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	10	Various Equipment	19,668	Vent Lease LLC		5,136	$ (14,532)	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			$ 19,668			$ 5,136	$ * (14,532)	39

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	10	Nursing and Medical Records	$ 30,773	MAC Rx, LLC		$ 27,897	$ (2,876)	15
16	V	39	Ancillary	262,776	MAC Rx, LLC		238,217	(24,558)	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			$ 293,548			$ 266,114	$ * (27,434)	39

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group		$ 276,173	$ 276,173	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	276,173	CCS Employee Benefits Group			(276,173)	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			$ 276,173			$ 276,173	$ *	39

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	0	See Attached	1.38	3.44	Alloc Salary	$ 2,455	22-7	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	$ 2,455		13

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

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X]

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,219,947	38	$ 3,992	$	35,509	$ 116	1
2	02	Food	Patient Days	1,219,947	38	2,910		35,509	85	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856		35,509	1,015	3
4	05	Utilities	Patient Days	1,219,947	38	38,173		35,509	1,111	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040		35,509	2,213	5
6	17	Administrative	Patient Days	1,219,947	38			35,509		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408		35,509	4,523	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998		35,509	1,892	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251		35,509	9,962	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602		35,509	309	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988		35,509	582	11
12	26	Insurance	Patient Days	1,219,947	38	42,836		35,509	1,247	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209		35,509	1,956	13
14	32	Interest	Patient Days	1,219,947	38	240,208		35,509	6,992	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701		35,509	3,892	15
16	35	Rent - Equipment	Patient Days	1,219,947	38	7,304		35,509	213	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	575,856	35,509	16,761	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021		35,509	3,057	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	499,202	35,509	14,530	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	3,529,267	35,509	102,726	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685		35,509	21,384	21
22										22
23										23
24										24
25	TOTALS					$ 6,684,506	$ 4,604,325		$ 194,566	25

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Salary	Patient Days	603,308	20	$ 8,692	$ 8,692	35,509	$ 512	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		35,509	136	2
3	5	Utilities	Patient Days	603,308	20	2,264		35,509	133	3
4	6	Maintenance	Patient Days	603,308	20	2,283		35,509	134	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		35,509	75	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	35,509	28,970	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		35,509	750	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	35,509	13,423	8
9	15	Emp. Ben, - Direct Alloc.	Direct Allocation		4	44,957				9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		35,509	6,230	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	35,509	85,483	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		35,509	1,187	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220			3,140	13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		35,509	981	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	35,509	42,601	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		35,509	2,041	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		35,509	336	17
18	26	Insurance	Patient Days	603,308	20	5,874		35,509	346	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		35,509	18,824	19
20	30	Depreciation	Patient Days	603,308	20	2,099		35,509	124	20
21	32	Interest	Patient Days	603,308	20	1,914		35,509	113	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		35,509	520	22
23										23
24										24
25	TOTALS					$ 3,507,824	$ 2,905,144		$ 206,059	25

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Various Equipment	Direct Allocation						5,136	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					$	$		$ 5,136	25

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 27,897	1
2	39	Ancillary	Direct Allocation						238,217	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					$	$		$ 266,114	25

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 276,173	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					$	$		$ 276,173	25

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CIBC Bank		X	Mortgage			$	$ 9,845,350			$ 540,981	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBM Bank		X	Line of Credit							7,580	6
7	Alliance Laundry Systems		X	Note Payable F & E				9,694			1,644	7
8	SBA Loan		X					2,800			898	8
9	TOTAL Facility Related						$	$ 9,857,844			$ 551,103	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,496)	10
11	Alloc from Extended Care Consulting										6,992	11
12	Alloc from Extended Care Clinical										113	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (391)	14
15	TOTALS (line 9+line14)						$	$ 9,857,844			$ 550,712	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 Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 322,491	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.)		$ 316,871	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,619)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 308,595	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.)		$ 13	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.		$ 302,989	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	178,218	8
	2016	179,750	9
	2017	281,150	10
	2018	325,693	11
	2019	312,459	12

2019 Accrual = $312,459 x 1.05 = $328,082
Allocated from Extended Care Consulting $3892
Allocated from Extended Care Clinical $520

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIOI	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beecher Manor Nrsg Rehab Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0047738

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 nursin 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-22-16-200-021-0000	Long Term Care Property	$ 4,159.80	$ 4,159.80
2.	22-22-16-200-028-0000	Long Term Care Property	$ 308,299.56	$ 308,299.56
3.	See Attached	Alloc from Extended Care Consulting	$ 197,162.69	$ 3,891.64
4.	See Attached	Alloc from Extended Care Clinical	$ 197,162.69	$ 519.98
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 706,784.74	$ 316,870.98

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beecher Manor Nrsg Rehab Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0047738

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	123,116	2006	$ 163,718	1
2	Allocated from Care Center Building			18,348	2
3	TOTALS	123,116		$ 182,066	3

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	130		2006	1985	$ 2,546,584	$ 731,347	39	$ 65,297	$ (666,050)	$ 971,292	4
5				2008	1,794,872		39	46,022	46,022	569,549	5
6				2009	3,618,157		39	92,773	92,773	1,107,214	6
7				2010	4,953		39	127	127	1,362	7
8											8
	Improvement Type**										
9	Various			2006	44,583		20	2,229	2,229	32,091	9
10	Various			2007	35,433		20	1,641	1,641	25,330	10
11	Various			2008	107,367		20	4,486	4,486	74,283	11
12	Various			2009	113,868		20	1,540	1,540	100,764	12
13	Various			2010	20,273		20	858	858	12,170	13
14	Various			2011	3,519		20			3,519	14
15	Various			2012	56,708		20	2,082	2,082	33,204	15
16	Various			2013	54,694		20	2,735	2,735	29,490	16
17	Various			2014	8,280		20	414	414	2,755	17
18	Various			2015	33,322		20	1,667	1,667	9,411	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		7,780,686			389,034	389,034	1,167,103	67
68	Related Party Allocations (Pages 12H & 12I)		91,259	1,415		1,415		64,394	68
69	Financial Statement Depreciation			62,213			(62,213)		69
70	TOTAL (lines 4 thru 69)		$ 16,314,558	$ 794,975		$ 612,321	$ (182,654)	$ 4,203,931	70

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 16,314,558	$ 794,975		$ 612,321	$ (182,654)	$ 4,203,931	1
2	2 White Sinks	2017	8,990		20	450	450	1,799	2
3	Wireless Access Points	2017	15,480		20	774	774	2,709	3
4	Faux Stucco Exterior Sign With Light Fixtures	2017	22,364		20	1,118	1,118	3,820	4
5	2 Trane 7.5 Ton Condensers	2018	21,400		20	1,070	1,070	2,764	5
6	Repaired Kitchen	2018	4,000		20	200	200	500	6
7	Walk In Cooler And Freezer Doors Replacement	2018	7,303		20	365	365	913	7
8	13 Custom Cornice Boards	2018	5,500		20	275	275	619	8
9	Double Face Sign Preparation	2018	5,275		20	264	264	594	9
10	Patio And Landscaping	2018	39,699		20	1,985	1,985	4,301	10
11	Repaired Walk-In Freezer	2018	6,339		20	317	317	713	11
12	Annunciator For Doors And Connection To Voice Announcement	2019	4,720		20	236	236	354	12
13	Installation Of Maglocks & Set To Sound Alarm-300 & 600 Hallwa	2019	4,149		20	207	207	311	13
14	New Heat Exchangers For Rooftop Units	2019	3,300		20	165	165	330	14
15	Three A/C'S	2019	4,447		20	222	222	444	15
16	Window Blinds In 43 Patient Rooms, And Break Room	2019	4,500		20	225	225	450	16
17	Courtyard - Install Steel Edging, Plant Trees And Shrubs	2019	11,586		20	579	579	579	17
18	Silicone Installation On Roof Membrane	2020	77,500		20	2,208	2,208	2,208	18
19	Generator Upgrade - Retrofit Battery Charger	2020	4,557		20	228	228	228	19
20	Door - Installation Of New Maglock With 2 Sirens	2020	2,846		20	142	142	142	20
21	Door - Installed 2 Magnetic Locks	2020	4,422		20	221	221	221	21
22	Repair 10 Exhaust Fans With Burned Out Motors	2020	3,713		20	186	186	186	22
23	Rms 311,313,318,410,412-Fix Rm Light & Door Closures	2020	3,150		20	158	158	158	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)		$ 16,579,798	$ 794,975		$ 623,916	$ (171,059)	$ 4,228,274	34

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 16,579,798	$ 794,975		$ 623,916	$ (171,059)	$ 4,228,274	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,579,798	$ 794,975		$ 623,916	$ (171,059)	$ 4,228,274	34

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 16,579,798	$ 794,975		$ 623,916	$ (171,059)	$ 4,228,274	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,579,798	$ 794,975		$ 623,916	$ (171,059)	$ 4,228,274	34

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 16,579,798	$ 794,975		$ 623,916	$ (171,059)	$ 4,228,274	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 16,579,798	$ 794,975		$ 623,916	$ (171,059)	$ 4,228,274	34

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Facility Renovation: contractor fee, demolition, concrete,	2018	7,780,686		20	389,034	389,034	1,167,103	9
10	site utilities, structural steel, masonry, roofing, doors,								10
11	fence, paving, insulation, ceilings, millwork, flooring,								11
12	painting, fire protection, HVAC, plumbing, drywall,								12
13	carpentry, electrical, landscaping								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)		$ 7,780,686	$		$ 389,034	$ 389,034	$ 1,167,103	34

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 12F, Carried Forward		$ 7,780,686	$		$ 389,034	$ 389,034	$ 1,167,103	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,780,686	$		$ 389,034	$ 389,034	$ 1,167,103	34

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	22,304	572	35	572		10,461	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	6,986	155	35	155		2,089	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,980	76	35	76		1,396	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	18,425		20			18,425	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	21,713		20			21,713	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,079		20			1,079	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	195	10	20	10		117	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,868	93	20	93		654	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	307	15	20	15		199	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,213	61	20	61		303	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,103	105	20	105		421	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	964	48	20	48		145	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	363	18	20	18		36	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	97	5	20	5		5	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,462		20			2,462	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2003	2,901		20			2,901	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2005	144		20			144	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2009	26	1	20	1		16	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2014	242	12	20	12		85	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2015	41	2	20	2		27	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2016	162	8	20	8		40	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2017	281	14	20	14		56	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2018	129	6	20	6		19	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2019	48	2	20	2		5	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2020	13	1	20	1		1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 87,046	$ 1,205		$ 1,205	$	$ 62,798	34

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 87,046	$ 1,205		$ 1,205	$	$ 62,798	1
2									2
3									3
4									4
5	Leasehold Improvements:								5
6	Allocated from Extended Care Consulting	2007	134	7	20	7		94	6
7	Allocated from Extended Care Consulting	2009	80	4	20	4		48	7
8	Allocated from Extended Care Consulting	2010	785	39	20	39		432	8
9	Allocated from Extended Care Consulting	2011	283	14	20	14		141	9
10	Allocated from Extended Care Consulting	2012	93	5	20	5		42	10
11	Allocated from Extended Care Consulting	2014	1,291	65	20	65		452	11
12	Allocated from Extended Care Consulting	2016	1,548	77	20	77		387	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)		$ 91,259	$ 1,415		$ 1,415	$	$ 64,394	34

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

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 301,668	$ 663	$ 29,142	$ 28,479	10	$ 119,440	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	771,225				10	339,527	73
74								74
75	TOTALS	$ 1,072,893	$ 663	$ 29,142	$ 28,479		$ 458,967	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 Clinical	2012	$ 3,024	$	$	$	5	$ 3,024	76
77		Alloc. Extended Care Consulting	2014	741				5	741	77
78										78
79										79
80	TOTALS			$ 3,765	$	$	$		$ 3,765	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)	$ 17,838,522	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 795,639	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 653,059	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (142,580)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,691,006	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 Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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: *

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 2,445 Description: See Attached
(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 Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 374,049	$		$ 374,049	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			104,888			104,888	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			358,641			358,641	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				236,836		236,836	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					5,740	100,566		106,306	13
14	TOTAL			$		$ 843,318	$ 337,402		$ 1,180,720	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 Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 1,198,276	$ 1,206,829	1
2	Cash-Patient Deposits	47,916	47,916	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	510,736	510,736	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	128,836	128,836	6
7	Other Prepaid Expenses	7,392	7,392	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,893,156	$ 1,901,709	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		14,320,142	14
15	Leasehold Improvements, at Historical Cost	610,840	958,097	15
16	Equipment, at Historical Cost	489,361	1,888,946	16
17	Accumulated Depreciation (book methods)	(857,568)	(6,478,086)	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): See Attached	5,711,542	3,889,977	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,954,175	$ 14,742,794	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,847,331	$ 16,644,503	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 871,984	$ 871,985	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,684	42,684	28
29	Short-Term Notes Payable	9,694	9,694	29
30	Accrued Salaries Payable	260,590	260,590	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,151	9,151	31
32	Accrued Real Estate Taxes(Sch.IX-B)	308,595	308,595	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	5,879	5,879	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,508,577	$ 1,508,578	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,800	2,800	39
40	Mortgage Payable		9,845,350	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,180,337	1,180,337	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,183,137	$ 11,028,487	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,691,714	$ 12,537,065	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,155,617	$ 4,107,438	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,847,331	$ 16,644,503	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,102,575	1
2	Restatements (describe):		2
3	Real Estate Tax	19,487	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,122,062	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	417,555	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	(384,000)	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)**	$ 33,555	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)**	$ 5,155,617	24 *

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

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,352,095	1
2	Discounts and Allowances for all Levels	(3,964,354)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,387,741	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,739,055	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,739,055	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		13
14	Non-Patient Meals	228	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	241,419	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	139,381	19
20	Radiology and X-Ray	142,494	20
21	Other Medical Services	52,161	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 575,683	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,496	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,496	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,206,479	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,206,479	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,916,454	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,765,976	31
32	Health Care	4,476,520	32
33	General Administration	2,353,781	33
	B. Capital Expense		
34	Ownership	1,453,131	34
	C. Ancillary Expense		
35	Special Cost Centers	1,181,336	35
36	Provider Participation Fee	268,155	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,498,899	40
41	**Income before Income Taxes (line 30 minus line 40)****	417,555	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 417,555	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,444,732	44
45	Private Pay - Net Inpatient Revenue	1,422,155	45
46	Medicare - Net Inpatient Revenue	769,660	46
47	Other-(specify) Hospice	789,275	47
48	Other-(specify) Insurance	(38,081)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,387,741	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.**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,617	2,202	$ 126,901	$ 57.62	1
2	Assistant Director of Nursing	2,014	2,469	106,192	43.00	2
3	Registered Nurses	21,838	23,383	843,187	36.06	3
4	Licensed Practical Nurses	29,141	31,588	1,081,179	34.23	4
5	CNAs & Orderlies	37,702	40,785	615,310	15.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,447	3,643	62,275	17.10	8
9	Activity Director	1,667	2,110	47,358	22.45	9
10	Activity Assistants	6,535	7,110	81,825	11.51	10
11	Social Service Workers	7,753	8,512	209,496	24.61	11
12	Dietician					12
13	Food Service Supervisor	3,979	4,592	113,214	24.65	13
14	Head Cook	8,641	9,474	122,765	12.96	14
15	Cook Helpers/Assistants	15,829	17,442	186,375	10.69	15
16	Dishwashers					16
17	Maintenance Workers	5,756	6,266	122,568	19.56	17
18	Housekeepers	15,929	16,874	204,981	12.15	18
19	Laundry	5,254	5,334	63,176	11.84	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,502	2,709	43,564	16.08	23
24	Clerical	9,972	10,425	167,066	16.03	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	2,188	2,424	45,377	18.72	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	4,558	5,882	89,670	15.25	33
34	TOTAL (lines 1 - 33)	186,321	203,224	$ 4,332,479 *	$ 21.32	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	591	$ 29,047	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,706	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Per Visit	1,877	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	ER Consultant	Per Visit	641	10-03	47
48					48
49	TOTAL (lines 35 - 48)	591	$ 57,271		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	89	$ 6,895	10-03	50
51	Licensed Practical Nurses	872	53,961	10-03	51
52	Certified Nurse Assistants/Aides	24,529	647,012	10-03	52
53	TOTAL (lines 50 - 52)	25,490	$ 707,868		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 29,500
ProPay	Payroll Processing	23,967
Ability	Medicare Billing Services	20,559
National Datacare Corporation	Resident Fund Processing	1,388
ECC Clinical	Home Office Expense	108,660
ECC Consulting	Home Office Expense	343,944
Personnel Planners	Unemployment Tax Consultant	1,225
IIT/Sourcetech	Data Processing	605
Pinnacle Quality Insight	Customer Satisfaction	870
Red Eyed Moose	Software Support	2,652
See Attached	Legal	6,092
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 539,462

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 130,919
Unemployment Compensation Insurance	20,617
FICA Taxes	331,435
Employee Health Insurance	156,272
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	129
Other Employee Welfare	65,043
Holiday Expense	560
TOTAL (agree to Schedule V, line 22, col.8)	$ 704,975

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,492
Advertising: Employee Recruitment	125,465
Health Care Worker Background Check	
(Indicate # of checks performed 312)	3,243
Patient Background Checks	
Dues & Subscriptions	25,890
Licenses & Fees	5,460
See Supplemental Schedule	2,873
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 164,423

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,127
See Supplemental Schedule	645
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,772

**See instructions.

Facility Name & ID Number Beecher Manor Nrsg Rehab Ctr # 0047738 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. **HCCI - $14,213**

(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. $ **54,186** 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. $ **268,155**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ ____ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **228**

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

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.