

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

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.

<p>I. IDPH Facility ID Number: <u>0042135</u></p> <p>Facility Name: <u>Bethany Health Care & Rehab Ct</u></p> <p>Address: <u>Resource Parkway</u> <u>Dekalb</u> <u>60115</u> Number City Zip Code</p> <p>County: <u>Dekalb</u></p> <p>Telephone Number: <u>(815) 756-5526</u> Fax # _____</p> <p>IDPA ID Number: <u>431776735</u></p> <p>Date of Initial License for Current Owners: _____</p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven D. Tenhouse, Olive LLP</u> Telephone Number: <u>(217) 753-1375</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____ (Type or Print Name) <u>Chad Butterfield, THCSLLC, Mgt. Co. for</u> (Title) <u>Bethany Health Care Center</u></td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>Olive LLP</u> (Firm Name & Address) <u>205 S. 5th Street, Suite 645, Springfield, IL 62701</u> (Telephone) <u>(217) 753-1375</u> Fax # <u>(217) 744-0193</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Chad Butterfield, THCSLLC, Mgt. Co. for</u> (Title) <u>Bethany Health Care Center</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Olive LLP</u> (Firm Name & Address) <u>205 S. 5th Street, Suite 645, Springfield, IL 62701</u> (Telephone) <u>(217) 753-1375</u> Fax # <u>(217) 744-0193</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bethany Health Care & Rehab Ct

0042135 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,940	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	90	TOTALS	90	32,940	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	197	209	3,131	3,537	8
9	SNF/PED	0	0	0		9
10	ICF	11,605	13,314	99	25,018	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	11,802	13,523	3,230	28,555	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.69%

D. How many bed-hold days during this year were paid by Public Aid?

100 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 11/04/97

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

YES Date 11/04/97 NO

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

YES NO If YES, enter number of beds certified 14 and days of care provided 3,081

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Bethany Health Care & Rehab Ct # 0042135 Report Period Beginning: 01/01/00 Ending: 12/31/00

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	176,683	10,535	15,258	202,476		202,476	(1,657)	200,819		1
2	Food Purchase		146,830		146,830		146,830	(543)	146,287		2
3	Housekeeping	1,655	6,309	77,638	85,602		85,602		85,602		3
4	Laundry		15,575	48,209	63,784		63,784		63,784		4
5	Heat and Other Utilities			99,096	99,096		99,096		99,096		5
6	Maintenance	29,839	22,570	34,761	87,170		87,170		87,170		6
7	Other (specify):*			2,357	2,357		2,357		2,357		7
8	TOTAL General Services	208,177	201,819	277,319	687,315		687,315	(2,200)	685,115		8
	B. Health Care and Programs										
9	Medical Director			2,328	2,328		2,328		2,328		9
10	Nursing and Medical Records	1,136,877	71,472	5,225	1,213,574		1,213,574		1,213,574		10
10a	Therapy										10a
11	Activities	48,034	2,184	3,877	54,095		54,095		54,095		11
12	Social Services	59,227	659	2,196	62,082		62,082		62,082		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,244,138	74,315	13,626	1,332,079		1,332,079		1,332,079		16
	C. General Administration										
17	Administrative	79,349	(69)		79,280		79,280		79,280		17
18	Directors Fees										18
19	Professional Services			191,945	191,945		191,945	(65,060)	126,885		19
20	Dues, Fees, Subscriptions & Promotions			48,734	48,734		48,734	(20,980)	27,754		20
21	Clerical & General Office Expenses	100,392	21,595	48,127	170,114		170,114	(49,187)	120,927		21
22	Employee Benefits & Payroll Taxes			226,135	226,135		226,135		226,135		22
23	Inservice Training & Education			2,877	2,877		2,877		2,877		23
24	Travel and Seminar			13,591	13,591		13,591		13,591		24
25	Other Admin. Staff Transportation			3,670	3,670		3,670		3,670		25
26	Insurance-Prop.Liab.Malpractice			55,579	55,579		55,579		55,579		26
27	Other (specify):*										27
28	TOTAL General Administration	179,741	21,526	590,658	791,925		791,925	(135,227)	656,698		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,632,056	297,660	881,603	2,811,319		2,811,319	(137,427)	2,673,892		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bethany Health Care & Rehab Ct #0042135 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			160,307	160,307		160,307	(15,009)	145,298			30
31	Amortization of Pre-Op. & Org.			6,211	6,211		6,211	(6,211)	0			31
32	Interest			346,865	346,865		346,865	(6)	346,859			32
33	Real Estate Taxes			83,297	83,297		83,297	96,515	179,812			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,522	9,522		9,522		9,522			35
36	Other (specify):*											36
37	TOTAL Ownership			606,202	606,202		606,202	75,290	681,492			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,587	246,562	314,149		314,149		314,149			39
40	Barber and Beauty Shops			12,487	12,487		12,487	(13,271)	(784)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,295	49,295		49,295		49,295			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		67,587	308,344	375,931		375,931	(13,271)	362,660			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,632,056	365,247	1,796,149	3,793,452		3,793,452	(75,408)	3,718,044			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Bethany Health Care & Rehab Ct**

0042135

Report Period Beginning: **01/01/00**

Ending: **12/31/00**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,657)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		39		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		32		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(38,094)	21		18
19	Entertainment				19
20	Contributions	(50)	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	(9,900)	21		24
25	Fund Raising, Advertising and Promotional	(20,930)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	62,098			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,538)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(6,211)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(60,660)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (66,871)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (75,408)		37

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

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

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

OHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Bethany Health Care & Rehab Ct

ID# 0042135

Report Period Beginning: 01/01/00

Ending: 12/31/00

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vendor Income	\$ 0	1	1
2	Barber and Beauty Revenue	(13,271)	40	2
3	Extraordinary Income/(Expense)			3
4	(Gain)/Loss on Sale of Assets	0	30	4
5	Miscellaneous (Income)/Expense	(1,193)	21	5
6	Adjust Depreciation Expense to Schedule XI	(19,409)	30	6
7	Raw foods rebate	(543)	2	7
8	Adjust Real Estate Taxes to actual	96,515	33	8
9				9
10				10
11				11
12				12
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88				88
89				89
90	Total		62,098	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethany Health Care & Rehab Ct# 0042135

Report Period Beginning:

01/01/00

Ending:

12/31/00

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,657)	0	0	0	0	0	0	0	0	0	0	(1,657)	1
2	Food Purchase	(543)	0	0	0	0	0	0	0	0	0	0	(543)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,200)	0	0	0	0	0	0	0	0	0	0	(2,200)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(65,060)	0	0	0	0	0	0	0	0	0	(65,060)	19
20	Fees, Subscriptions & Promotions	(20,980)	0	0	0	0	0	0	0	0	0	0	(20,980)	20
21	Clerical & General Office Expenses	(49,187)	0	0	0	0	0	0	0	0	0	0	(49,187)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(70,167)	(65,060)	0	(135,227)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(72,367)	(65,060)	0	(137,427)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethany Health Care & Rehab Ct# 0042135

Report Period Beginning:

01/01/00

Ending:

12/31/00

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(19,409)	4,400	0	0	0	0	0	0	0	0	0	(15,009)	30
31	Amortization of Pre-Op. & Org.	(6,211)	0	0	0	0	0	0	0	0	0	0	(6,211)	31
32	Interest	(6)	0	0	0	0	0	0	0	0	0	0	(6)	32
33	Real Estate Taxes	96,515	0	0	0	0	0	0	0	0	0	0	96,515	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	70,890	4,400	0	75,290	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(13,271)	0	0	0	0	0	0	0	0	0	0	(13,271)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(13,271)	0	0	0	0	0	0	0	0	0	0	(13,271)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(14,748)	(60,660)	0	(75,408)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Ownership information will be forwarded upon receipt. The offset for related parties has been calculated and included in the cost report.						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Services	\$ 146,524	Tutera Health Care Services LLC	100.00%	\$ 81,464	\$ (65,060)	1
2	V	30 Depreciation Expense				4,400	4,400	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 146,524			\$ 85,864	\$ * (60,660)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bethany Health Care & Rehab Ct # 0042135 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bethany Health Care & Rehab Ct

0042135

Report Period Beginning:

01/01/00

Ending: 12/31/00

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 Tutera Health Care Services
 Street Address 7611 State Line Road, Suite 301
 City / State / Zip Code Kansas City, MO 64114
 Phone Number (816) 444-0900
 Fax Number (816) 822-8799

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	19	Accounting and Mgt. Services	Direct Cost	130,167,805	12	\$ 3,700,702	\$ 0	2,865,392	\$ 81,464	1
2	30	Capitial Equipment	Direct Cost	130,167,805	12	199,867	0	2,865,392	4,400	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					\$ 3,900,569	\$		\$ 85,864	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Bethany Health Care & Rehab Ct

0042135

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	WMF Huntoon		X	Mortgage	Varies	7/01/97	\$ 3,645,000	\$ 3,593,591		8.50%	\$ 302,379	1						
2	Cambridge Realty		X	Note payable	\$6,880.00	4/12/00	898,100	896,338		8.25%	44,486	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Interest Income		X									(6)						
7	H/O Interest Income	X										7						
8												8						
9	TOTAL Facility Related				\$6,880.00		\$ 4,543,100	\$ 4,489,929			\$ 346,859	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,543,100	\$ 4,489,929			\$ 346,859	15						

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	72,324	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.)	\$	98,335	2
3. Under or (over) accrual (line 2 minus line 1).	\$	26,011	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	153,801	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. 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 19 _____ 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.	\$	179,812	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	8	
	1996	61,253	9
	1997	55,105	10
	1998	87,420	11
	1999	98,335	12
	FOR OFF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bethany Health Care & Rehab Ct

0042135 Report Period Beginning:

01/01/00 Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,083 B. General Construction Type: Exterior Face Brick Frame _____ Number of Stories 1

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

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

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

N/A

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

1. Total Amount Incurred: 245,355 2. Number of Years Over Which it is Being Amortized: Various
 3. Current Period Amortization: 6,211 4. Dates Incurred: Various

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>1997</u>	<u>\$ 303,889</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 303,889	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bethany Health Care & Rehab Ct# 0042135

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		97	97	\$ 3,353,760	\$ 83,844	40	\$ 83,844	\$	\$ 300,441	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Buildings and Improvements		97	54,146	1,354	40	1,354	(0)	4,851	9
10	Facility Outdoor Sign		97	1,620	108	15	108		360	10
11	Paging and Speaker System		97	1,466	37	40	37	(0)	131	11
12	Flooring		97	41,145	5,878	7	5,878	(0)	21,062	12
13	Carpet		97	2,535	362	7	362	0	1,297	13
14	Fire hood		97	2,425	242	10	243	1	869	14
15	Partner Plus Phones		97	3,028	606	5	606	(0)	2,170	15
16	Kitchen gas connector		97	274	27	10	27	0	98	16
17	Phones upgrade		97	1,544	309	5	309	(0)	1,106	17
18	Commercial softner		97	4,085	408	10	409	1	1,294	18
19	Telephone system		97	1,233	123	10	123	0	442	19
20	Window treatment		97	6,249	893	7	893	(0)	3,199	20
21	Fastners/Wiring		97	311	44	7	44	0	159	21
22	Fire alarm		98	3,200	213	15	213	0	444	22
23	Intercom system		98	5,799	828	7	828	0	2,132	23
24	Locked sign board and letters		98	844	121	7	121	(0)	241	24
25	Glass		98	377	54	7	54	(0)	135	25
26	Paging system		98	465	47	10	47	(1)	116	26
27	Lockers		98	1,206	121	10	121	(0)	301	27
28	Window treatment		98	1,492	213	7	213	0	426	28
29	Door holder-alarm system		99	658	66	10	66	(0)	77	29
30	Condensors-roof-move		99	3,600	240	15	240		380	30
31	Gazebo		99	3,998	266	15	267	1	422	31
32	Fan Control Kits		99	1,250	250	5	250		333	32
33	Kickplates, wallguards		99	7,659	511	15	511	(0)	766	33
34	Wallpaper border		2000	4,056	220	10	406	186	220	34
35	Sargent Fire Guard		2000	1,930	54	15	129	75	54	35
36	TOTAL (lines 4 thru 35)			\$ 3,510,355	\$ 97,439		\$ 97,699	\$ 260	\$ 343,526	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bethany Health Care & Rehab Ct

0042135

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Range outlet		2000	570	24	10	57	33	24	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)			\$ 570	\$ 24		\$ 57	\$ 33	\$ 24	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.

Facility Name & ID Number Bethany Health Care & Rehab Ct

0042135

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bethany Health Care & Rehab Ct

0042135

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bethany Health Care & Rehab Ct

0042135

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 298,183	\$ 41,384	\$ 42,598	\$ 1,214	7	\$ 135,617	37
38	Current Year Purchases	6,207	544	544		10	544	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 304,390	\$ 41,928	\$ 43,142	\$ 1,214		\$ 136,161	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,119,204	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 139,391	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 140,898	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 1,507	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 479,711	51

**

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	WIP	\$ 1,346	58
59			59
60			60
61		\$ 1,346	61

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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 Date of Lease	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: _____ *

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

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ 9,522 Description: See attached detail YES NO

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2001 \$ _____

13. _____ /2002 \$ _____

14. _____ /2003 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	7

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	4,995	\$ 88,767	\$ 423	4,995	\$ 89,190	1
2	Licensed Speech and Language Development Therapist		hrs		501	10,826	0	501	10,826	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		7,951	117,212	340	7,951	117,553	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	13,447	\$ 216,806	\$ 763	13,447	\$ 217,569	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bethany Health Care & Rehab Ct# 0042135Report Period Beginning: 01/01/00Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(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	\$ (31,251)	\$	1
2	Cash-Patient Deposits	297,564		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	708,435		3
4	Supply Inventory (priced at)	17,438		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,742		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,008,927	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	303,889		13
14	Buildings, at Historical Cost	3,581,071		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	335,726		16
17	Accumulated Depreciation (book methods)	(567,322)		17
18	Deferred Charges	245,355		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,898,718	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,907,646	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 277,036	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	153,801		29
30	Accrued Salaries Payable	147,224		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Other liab.'s and Patient Trust Dep	3,452		36
37	Due to affiliates	293,162		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 874,675	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,489,929		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,489,929	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,364,604	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (456,958)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,907,646	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 522,069	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 522,069	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(134,274)	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	(845,545)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	792	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (979,027)	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)	\$ (456,958)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,613,272	1
2	Discounts and Allowances for all Levels	(558,541)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,054,731	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	582,467	6
7	Oxygen	5,854	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 588,321	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	13,271	13
14	Non-Patient Meals	1,657	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,928	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Extraordinary Income/Loss & Misc.	1,193	28
28a	G/L on Sale of Asset		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,193	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,659,178	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	687,315	31
32	Health Care	1,332,079	32
33	General Administration	791,925	33
B. Capital Expense			
34	Ownership	606,202	34
C. Ancillary Expense			
35	Special Cost Centers	326,636	35
36	Provider Participation Fee	49,295	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,793,452	40
41	Income before Income Taxes (line 30 minus line 40)**	(134,274)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (134,274)	43

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

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

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

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

Facility Name & ID Number **Bethany Health Care & Rehab Ct**

0042135

Report Period Beginning:

01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	6,022	6,237	\$ 142,639	\$ 22.87	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	14,141	14,830	305,359	20.59	3
4	Licensed Practical Nurses	4,826	5,061	103,817	20.51	4
5	Nurse Aides & Orderlies	52,204	54,702	566,908	10.36	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	4,132	4,341	48,034	11.07	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	4,343	4,590	59,227	12.90	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	20,518	21,383	176,683	8.26	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,326	2,446	29,839	12.20	17
18	Housekeepers	211	221	1,655	7.49	18
19	Laundry	0	0	0		19
20	Administrator	2,148	2,224	79,349	35.68	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	8,675	8,982	100,392	11.18	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,831	1,896	18,155	9.58	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,377	126,913	\$ 1,632,055 *	\$ 12.86	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	335	\$ 12,464	line 1, col 3	35
36	Medical Director	55	8,640	line 9, col 3	36
37	Medical Records Consultant	96	4,032	line 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	78	3,197	line 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,620	line 11, col 3	44
45	Social Service Consultant	37	1,872	line 12, col 3	45
46	Other(specify) <u>Housekeeping</u>	5,081	71,150		46
47	<u>Laundry</u>	3,644	51,071		47
48					48
49	TOTAL (lines 35 - 48)	9,356	\$ 154,046		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	Ln 10, Col 1	50
51	Licensed Practical Nurses	240	7,947	Ln 10, Col 1	51
52	Nurse Aides		0	Ln 10, Col 1	52
53	TOTAL (lines 50 - 52)	240	\$ 7,947		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bethany Health Care & Rehab Ct# 0042135

Report Period Beginning:

01/01/00

Ending:

12/31/00**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? N
- (2) Are there any dues to nursing home associations included on the cost report? N
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? N If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? N If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Y
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,322 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Y If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES N NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO N If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 49,295
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? N If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Y
- (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? N 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. \$ N/A Has any meal income been offset against related costs? Y Indicate the amount. \$ 1,657
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? N
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? N 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? Y
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Y
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Y
- g. Does the facility transport residents to and from day training? N**
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? N
Firm Name: 0 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. Not required
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Y
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Y
Attach invoices and a summary of services for all architect and appraisal fees.