

		FOR BHF USE					

LL1

**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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.

**I. IDPH License ID Number:** 0042135

**Facility Name:** Bethany Health Care & Rehab Center

**Address:** Resource Parkway Dekalb 60115  
 Number City Zip Code

**County:** Dekalb

**Telephone Number:** 815-756-5526 Fax # ( )

**HFS ID Number:** 43-1776735

**Date of Initial License for Current Owners:** 1/28/1998

**Type of Ownership:**

<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
<b>IRS Exemption Code</b> _____	<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 _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Ken Marx, BKD, LLP **Telephone Number:** 314-231-5544

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2007 to 12/31/2007 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Clark Ribordy, THCSLLC, MGT. CO</u>	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____ Fax # ( ) _____	

**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 Bethany Health Care & Rehab Center# 0042135 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

## 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	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,850</u>	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	<u>90</u>	TOTALS	<u>90</u>	<u>32,850</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,455</u>	<u>10,425</u>	<u>7,082</u>	<u>30,962</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,455</u>	<u>10,425</u>	<u>7,082</u>	<u>30,962</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.25%

D. How many bed-hold days during this year were paid by the Department?

\_\_\_\_\_  
(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)

N/A-noneF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 &amp; 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 11/04/1997

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

YES  Date 11/4/1997 NO 

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

YES  NO  If YES, enter number of beds certified 90 and days of care provided 7,082Medicare Intermediary MUTUAL OF OMAHA

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	217,797	11,665	11,019	240,481		240,481	(570)	239,911		1
2	Food Purchase		158,395		158,395		158,395	(887)	157,508		2
3	Housekeeping		14,028	87,309	101,337		101,337		101,337		3
4	Laundry		12,242	58,206	70,448		70,448		70,448		4
5	Heat and Other Utilities			131,849	131,849		131,849		131,849		5
6	Maintenance	34,340	17,069	67,377	118,786		118,786		118,786		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	252,137	213,399	355,760	821,296		821,296	(1,457)	819,839		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,657	6,657		6,657		6,657		9
10	Nursing and Medical Records	1,748,382	162,394	55,095	1,965,871		1,965,871		1,965,871		10
10a	Therapy		766	629,289	630,055		630,055		630,055		10a
11	Activities	59,102	1,780	11,758	72,640		72,640		72,640		11
12	Social Services	108,755	18	3,412	112,185		112,185		112,185		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,916,239	164,958	706,211	2,787,408		2,787,408		2,787,408		16
	<b>C. General Administration</b>										
17	Administrative	92,846	729		93,575		93,575		93,575		17
18	Directors Fees										18
19	Professional Services			410,304	410,304		410,304		410,304		19
20	Dues, Fees, Subscriptions & Promotions			66,646	66,646		66,646	(39,063)	27,583		20
21	Clerical & General Office Expenses	121,707	35,869	179,803	337,379		337,379	(212,635)	124,744		21
22	Employee Benefits & Payroll Taxes			357,939	357,939		357,939		357,939		22
23	Inservice Training & Education			421	421		421		421		23
24	Travel and Seminar			5,510	5,510		5,510		5,510		24
25	Other Admin. Staff Transportation			5,415	5,415		5,415		5,415		25
26	Insurance-Prop.Liab.Malpractice			77,687	77,687		77,687		77,687		26
27	Other (specify):* <b>LEGAL SETTLEMENT</b>			62	62		62		62		27
28	<b>TOTAL General Administration</b>	214,553	36,598	1,103,787	1,354,938		1,354,938	(251,698)	1,103,240		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,382,929	414,955	2,165,758	4,963,642		4,963,642	(253,155)	4,710,487		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 Bethany Health Care & Rehab Center #0042135 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			114,848	114,848		114,848		114,848		30
31	Amortization of Pre-Op. & Org.			11,518	11,518		11,518	(11,518)			31
32	Interest			267,145	267,145		267,145	(2,150)	264,995		32
33	Real Estate Taxes			106,508	106,508		106,508		106,508		33
34	Rent-Facility & Grounds			2	2		2	10,166	10,168		34
35	Rent-Equipment & Vehicles			2,376	2,376		2,376	2,214	4,590		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			502,397	502,397		502,397	(1,288)	501,109		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		319,205	20,889	340,094		340,094		340,094		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee										42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		319,205	20,889	340,094		340,094		340,094		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,382,929	734,160	2,689,044	5,806,133		5,806,133	(254,443)	5,551,690		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 Bethany Health Care & Rehab Center

# 0042135

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(570)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,150)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(887)	2		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	(14,820)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,869)	21		24
25	Fund Raising, Advertising and Promotional	(39,063)	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	(7,735)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (121,094)		\$	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	(11,518)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(121,831)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (133,349)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (254,443)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		52

Bethany Health Care & Rehab Center

ID# 0042135

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	MISCELLANEOUS INCOME	\$ (7,735)	21
2			
3			
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49	<b>Total</b>	(7,735)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Bethany Health Care &amp; Rehab Center

# 0042135

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

## 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)	
	<b>A. General Services</b>													
1	Dietary	(570)	0	0	0	0	0	0	0	0	0	0	(570)	1
2	Food Purchase	(887)	0	0	0	0	0	0	0	0	0	0	(887)	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	<b>TOTAL General Services</b>	<b>(1,457)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,457)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	CNA 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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(39,063)	0	0	0	0	0	0	0	0	0	0	(39,063)	20
21	Clerical & General Office Expenses	(78,424)	(134,211)	0	0	0	0	0	0	0	0	0	(212,635)	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	<b>TOTAL General Administration</b>	<b>(117,487)</b>	<b>(134,211)</b>	<b>0</b>	<b>(251,698)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(118,944)</b>	<b>(134,211)</b>	<b>0</b>	<b>(253,155)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(11,518)	0	0	0	0	0	0	0	0	0	0	(11,518)	31
32	Interest	(2,150)	0	0	0	0	0	0	0	0	0	0	(2,150)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	10,166	0	0	0	0	0	0	0	0	0	10,166	34
35	Rent-Equipment & Vehicles	0	2,214	0	0	0	0	0	0	0	0	0	2,214	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(13,668)</b>	<b>12,380</b>	<b>0</b>	<b>(1,288)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(132,612)</b>	<b>(121,831)</b>	<b>0</b>	<b>(254,443)</b>	<b>45</b>								

Facility Name & ID Number Bethany Health Care & Rehab Center

# 0042135

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

**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
TUTERA HEALTH CARE SERVICES	100					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	34 Building and Fixtures	\$	Tutera Health Care Services, LLC	100.00%	\$ 10,166	\$ 10,166 1
2	V	35 Moveable Equipment		Tutera Health Care Services, LLC	100.00%	2,214	2,214 2
3	V	21 Non-Capital	330,916	Tutera Health Care Services, LLC	100.00%	196,705	(134,211) 3
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 330,916			\$ 209,085	\$ * (121,831) 14

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

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Bethany Health Care & Rehab Center

# 0042135

Report Period Beginning: 1/1/2007

Ending: 2/31/2007

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 ( 816-822-1723

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	21	Non-Capital	Direct Cost	106,261,921	16	\$ 4,181,214	\$ 4,999,064	\$ 196,704	1
2	34	Capital Building	Direct Cost	106,261,921	16	216,096	4,999,064	10,166	2
3	35	Capital Equipment	Direct Cost	106,261,921	16	47,053	4,999,064	2,214	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					\$ 4,444,363	\$	\$ 209,084	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	WMF HUNTOON		X	MORTGAGE	\$39,452.00	7/1/1997	\$ 3,645,000	\$ 3,396,967		0.0850	\$ 249,965	1					
2	CAMBRIDGE REALTY		X	NOTES PAYABLE	\$6,880.00	4/12/2000	898,100	846,056		0.0825	17,181	2					
3	TGI		X	LINE OF CREDIT			25,000	25,000				3					
4												4					
5												5					
<b>Working Capital</b>																	
6	INTEREST INCOME		X								(2,150)	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>				\$46,332.00		\$ 4,568,100	\$ 4,268,023			\$ 264,996	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 4,568,100	\$ 4,268,023			\$ 264,996	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* 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 Bethany Health Care & Rehab Center

# 0042135 Report Period Beginning:

1/1/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 37,083 B. General Construction Type: Exterior BRICK Frame BLOCK Number of Stories 1

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

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

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

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

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

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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: 100,136 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: 11,518 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	<u>FACILITY</u>	<u>37,803</u>	<u>1997</u>	<u>\$ 303,889</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>37,803</b>		<b>\$ 303,889</b>	<b>3</b>

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. 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.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Bethany Health Care & Rehab Center COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0042135

CONTACT PERSON REGARDING THIS REPORT JUNIOR FOSTER, THCSLLC, MGMT CO.

TELEPHONE 816-444-0900 FAX #: 816-822-1723

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

Enter the tax index number and real estate tax assessed for 2006 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 2006.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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 &amp; ID Number Bethany Health Care &amp; Rehab Center

# 0042135

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	90		1997	1997	\$ 3,347,204	\$ 83,680	40	\$ 83,680	\$	\$ 885,771	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		REMOVAL OF ASPHALT, EXCAVATE GRAVEL		2001	2,450	306	8	306		1,889	9
10		CLEAN AND SEAL PARKING LOT		2002	2,140	268		268		1,449	10
12		PAGING & SPEAKER SYSTEM			1,466.29	36.66		36.66		387.98	12
13		BUILDING & IMPROVEMENTS			54,145.88	1,353.65		1,353.65		14,326.10	13
14		FLOORING			41,145.00					41,145.00	14
15		CARPET			2,534.44					2,534.44	15
16		SIGN-FACILITY			1,620.00	108.00		108.00		1,413.30	16
17		Fire Alarm			3,200.00	213.33		213.33		1,937.75	17
18		Condensers-roof-move			3,600.00	240.00		240.00		2,060.00	18
19		Gazebo			3,998.38	266.56		266.56		2,287.97	19
20		KICKPLATES, WALLGUARDS			7,658.92	510.60		510.60		4,340.10	20
21		FAN CONTROL KITS-9			1,250.00					1,250.00	21
22		140 ROLLS WALLPAPER BORDER			2,055.96	205.60		205.60		1,559.13	22
23		WALLPAPER BORDER			2,000.00	200.00		200.00		1,500.00	23
24		RANGE OUTLET IN LR			569.89	56.99		56.99		422.69	24
25		HOLD OPEN/CLOSE DOOR ALARM			1,930.00	128.67		128.67		954.30	25
26		Door Alarm System			4,951.17	330.08		330.08		2,283.05	26
27		Floor Strips (between carpet and tile)			763.48	76.35		76.35		515.36	27
28		Door Alarm Upgrade			1,653.86	110.26		110.26		725.88	28
29		Keypads for Alarm System (7 qty)			3,597.45	359.75		359.75		2,248.45	29
30		Replaced Monitor			989.19	98.92		98.92		610.01	30
31		Soft Water Mineral Tank			899.79	89.98		89.98		524.88	31
32		Doors and Trim for Res and Common Rms			500.00	58.33		58.33		500.00	32
33		Compressor for A/C Unit			1,011.00	67.40		67.40		365.08	33
34		Hallway carpet			7,802.49	1,560.49		1,560.49		7,802.49	34
35		Electric Heat A/C Unit (2)			1,013.19	101.32		101.32		447.50	35
36		Storage sheds(2)			3,014.85	150.74		150.74		628.08	36

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Heat lamps in shower room		3,648.48	364.85		364.85		1,520.21	37
38	Rooftop A/C unit		5,175.00	517.50		517.50		1,854.38	38
39	Wanderguary system for front door		1,616.80	161.68		161.68		538.93	39
40	Nurse station		11,452.50	763.50		763.50		2,417.75	40
41	Carpet for dining room		2,715.00	543.00		543.00		588.25	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,529,773	\$ 92,928		\$ 92,928	\$	\$ 988,798	70

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

**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:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	<u>2008</u>	\$ _____
13.	<u>2009</u>	\$ _____
14.	<u>2010</u>	\$ _____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 2,375 Description: \_\_\_\_\_

(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	<b>TOTAL</b>		\$	\$	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 Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 455,707	\$ 20,526	\$ 20,526	\$		\$ 384,474	71
72	Current Year Purchases	12,600	1,394	1,394			1,394	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 468,307	\$ 21,920	\$ 21,920	\$		\$ 385,868	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 4,301,969	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 114,848	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 114,848	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,374,666	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.

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

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

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

- (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.

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

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

## 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	10A,3	hrs	\$	6,300	\$ 282,424	\$	6,300	\$ 282,424	1
2	Licensed Speech and Language Development Therapist	10A,3	hrs		261	34,624		261	34,624	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A,3	hrs		3,499	312,240		3,499	312,240	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			\$	10,060	\$ 629,288	\$	10,060	\$ 629,288	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 Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2007 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 793,015	\$	1
2	Cash-Patient Deposits	21,080		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	871,710		3
4	Supply Inventory (priced at )	16,520		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,833		6
7	Other Prepaid Expenses	265,218		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,983,376	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	303,889		13
14	Buildings, at Historical Cost	3,625,319		14
15	Leasehold Improvements, at Historical Cost	4,590		15
16	Equipment, at Historical Cost	468,306		16
17	Accumulated Depreciation (book methods)	(1,474,429)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	379,113		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(81,480)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>FIXED ASSET ADJ</b>	(170,670)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,054,638	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,038,014	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 296,257	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,080		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,908		30
31	Accrued Taxes Payable (excluding real estate taxes)	135,728		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	16,774		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>OTHER ACCRUED EXPENSES</b>	(10,207)		36
37	<b>NOTE PAYABLE-TGI</b>	25,000		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 554,540	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	850,234		39
40	Mortgage Payable	3,396,967		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,247,201	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,801,741	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 236,273	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,038,014	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(381,668)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(381,668)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>617,941</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>617,941</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>236,273</b>	<b>24</b> *

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

Facility Name & ID Number Bethany Health Care & Rehab Center# 0042135Report Period Beginning: 1/1/2007Ending: 12/31/2007**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,870,552	1
2	Discounts and Allowances for all Levels	(423,491)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,447,061</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,200,437	6
7	Oxygen	20,181	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,220,618</b>	8
<b>C. Other Operating Revenue</b>			
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	570	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	610,135	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,797	19
20	Radiology and X-Ray		20
21	Other Medical Services	95,009	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 746,511</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,149	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,149</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISCELLANEOUS INCOME</b>	<b>7,735</b>	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 7,735</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,424,074</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	821,296	31
32	Health Care	2,787,408	32
33	General Administration	1,354,938	33
<b>B. Capital Expense</b>			
34	Ownership	502,397	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	340,094	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,806,133</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>617,941</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 617,941</b>	43

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

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

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

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

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

# **0042135**

Report Period Beginning: **1/1/2007**

Ending:

**12/31/2007**

**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	8,541	8,676	\$ 110,611	\$ 12.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,348	10,520	180,672	17.17	3
4	Licensed Practical Nurses	11,666	11,849	149,772	12.64	4
5	CNAs & Orderlies	52,281	52,542	254,244	4.84	5
6	CNA Trainees	4,170	4,253	24,172	5.68	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,065	5,273	25,768	4.89	10
11	Social Service Workers	5,544	5,623	41,750	7.42	11
12	Dietician	21,769	21,864	80,671	3.69	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,889	1,983	14,264	7.19	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	9,589	9,775	89,976	9.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,012	1,027	5,742	5.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,814	1,838	10,937	5.95	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,688	135,223	\$ 988,579 *	\$ 7.31	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

**C. CONTRACT NURSES**

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

Facility Name & ID Number Bethany Health Care & Rehab Center

# 0042135

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
GREG NIENABER	ADMINISTRATOR		\$ 92,846	Workers' Compensation Insurance	\$ 121,301	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	24,151	
				FICA Taxes	214,622	Health Care Worker Background Check		
				Employee Health Insurance	20,653	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING AND PR	39,063	
				OTHER	1,362	DUES AND SUBSCRIPTIONS	1,449	
						LICENSES	1,983	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 92,846					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	5,510
							Seminar Expense	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Entertainment Expense	( )
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type	Amount		\$			\$	
TUTERA HEALTH SERVICES	MANAGEMENT FEES	\$ 330,916					5,510	
BKD, LLP	ACCOUNTING FEES	22,221						
PLEASE SEE ATTACHED	PURCHASED SERVICES	25,345						
PLEASE SEE ATTACHED	LEGAL FEES	15,090						
PLEASE SEE ATTACHED	DATA PROCESSING FEES	16,116						
PINNACLE CONSULTING	PROFESSIONAL FEES	615						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 410,303					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Bethany Health Care &amp; Rehab Center

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,152 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. \$ 0  
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. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 433
- (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? 0
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
- 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 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/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.