

Facility Name & ID Number Bethany Rehabilitation & Health Care Center

0048934 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	32,850	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	90	TOTALS	90	32,850	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	13,194	4,929	9,100	27,223	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,194	4,929	9,100	27,223	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.87%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1/28/1998

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/28/1998 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 6,166

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		7,009	511,556	518,565		518,565		518,565		1
2	Food Purchase		11,476		11,476		11,476	(3,105)	8,371		2
3	Housekeeping		12,419	104,496	116,915		116,915		116,915		3
4	Laundry		19,190	69,599	88,789		88,789		88,789		4
5	Heat and Other Utilities			112,471	112,471		112,471		112,471		5
6	Maintenance	71,122	22,291	89,335	182,748		182,748		182,748		6
7	Other (specify):*										7
8	TOTAL General Services	71,122	72,385	887,457	1,030,964		1,030,964	(3,105)	1,027,859		8
	B. Health Care and Programs										
9	Medical Director					11,000	11,000		11,000		9
10	Nursing and Medical Records	2,170,957	122,951	61,260	2,355,168	(11,000)	2,344,168	4,753	2,348,921		10
10a	Therapy										10a
11	Activities	33,735	3,914	59,463	97,112		97,112		97,112		11
12	Social Services	84,082		2,434	86,516		86,516		86,516		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,288,774	126,865	123,157	2,538,796		2,538,796	4,753	2,543,549		16
	C. General Administration										
17	Administrative	117,199			117,199		117,199		117,199		17
18	Directors Fees										18
19	Professional Services			152,920	152,920		152,920	378,236	531,156		19
20	Dues, Fees, Subscriptions & Promotions			16,812	16,812		16,812	(2,982)	13,830		20
21	Clerical & General Office Expenses	148,510	28,249	589,157	765,916		765,916	(564,657)	201,259		21
22	Employee Benefits & Payroll Taxes			355,530	355,530		355,530		355,530		22
23	Inservice Training & Education			2,775	2,775		2,775		2,775		23
24	Travel and Seminar			2,172	2,172		2,172		2,172		24
25	Other Admin. Staff Transportation			1,342	1,342		1,342		1,342		25
26	Insurance-Prop.Liab.Malpractice			208,860	208,860		208,860		208,860		26
27	Other (specify):*										27
28	TOTAL General Administration	265,709	28,249	1,329,568	1,623,526		1,623,526	(189,403)	1,434,123		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,625,605	227,499	2,340,182	5,193,286		5,193,286	(187,755)	5,005,531		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			11,078	11,078		11,078	145,453	156,531			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			267	267		267	90,136	90,403			32
33	Real Estate Taxes			127,401	127,401		127,401	1,382	128,783			33
34	Rent-Facility & Grounds			287,554	287,554		287,554	(287,554)				34
35	Rent-Equipment & Vehicles			9,373	9,373		9,373		9,373			35
36	Other (specify):* Mortgage Ins							20,220	20,220			36
37	TOTAL Ownership			435,673	435,673		435,673	(30,363)	405,310			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		384,496	921,701	1,306,197		1,306,197		1,306,197			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			177,268	177,268		177,268		177,268			42
43	Other (specify):* Marketing	80,938		24,616	105,554		105,554	(105,554)				43
44	TOTAL Special Cost Centers	80,938	384,496	1,123,585	1,589,019		1,589,019	(105,554)	1,483,465			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,706,543	611,995	3,899,440	7,217,978		7,217,978	(323,672)	6,894,306			45

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

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	(3,105)	2		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	7,371	30		9
10	Interest and Other Investment Income	(35,170)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(14,420)	21		19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(85,912)	21		24
25	Fund Raising, Advertising and Promotional	(105,554)	43		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	(4,872)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (242,662)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(81,010)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (81,010)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (323,672)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Bethany Rehabilitation & Health Care Center

ID# 0048934

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lobbying Dues	\$ (1,785)	20	1
2	PAC Dues	(432)	20	2
3	Chamber of Commerce	(715)	20	3
4	Misc Income	(1,890)	21	4
5	Marketing Petty Cash Transactions	(50)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,872)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethany Rehabilitation & Health Care Center# 0048934

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,105)	0	0	0	0	0	0	0	0	0	0	(3,105)	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	(3,105)	0	0	0	0	0	0	0	0	0	0	(3,105)	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	4,753	0	0	0	0	0	0	0	0	0	4,753	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	TOTAL Health Care and Programs	0	4,753	0	0	0	0	0	0	0	0	0	4,753	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	13,863	364,373	0	0	0	0	0	0	0	0	378,236	19
20	Fees, Subscriptions & Promotions	(2,982)	0	0	0	0	0	0	0	0	0	0	(2,982)	20
21	Clerical & General Office Expenses	(103,222)	1,375	(462,810)	0	0	0	0	0	0	0	0	(564,657)	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	(106,204)	15,238	(98,437)	0	(189,403)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(109,309)	19,991	(98,437)	0	(187,755)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethany Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,371	129,933	8,149	0	0	0	0	0	0	0	0	145,453	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(35,170)	125,573	(267)	0	0	0	0	0	0	0	0	90,136	32
33	Real Estate Taxes	0	1,382	0	0	0	0	0	0	0	0	0	1,382	33
34	Rent-Facility & Grounds	0	(287,554)	0	0	0	0	0	0	0	0	0	(287,554)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	20,220	0	0	0	0	0	0	0	0	0	20,220	36
37	TOTAL Ownership	(27,799)	(10,446)	7,882	0	(30,363)	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	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):*	(105,554)	0	0	0	0	0	0	0	0	0	0	(105,554)	43
44	TOTAL Special Cost Centers	(105,554)	0	0	0	0	0	0	0	0	0	0	(105,554)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(242,662)	9,545	(90,555)	0	(323,672)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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 Rent	\$ 287,554	Dekalb Health Enterprises	100.00%	\$	(287,554)	1
2	V	32 Interest		Dekalb Health Enterprises	100.00%	116,377	116,377	2
3	V	19 Administrative		Dekalb Health Enterprises	100.00%	13,863	13,863	3
4	V	36 Mortgage Insurance Premium		Dekalb Health Enterprises	100.00%	20,220	20,220	4
5	V	30 Depreciation		Dekalb Health Enterprises	100.00%	129,933	129,933	5
6	V	32 Amortizaation of Financing Costs		Dekalb Health Enterprises	100.00%	9,196	9,196	6
7	V	33 Real Estate Taxes	127,401	Dekalb Health Enterprises	100.00%	128,783	1,382	7
8	V	26 Insurance	13,851	Dekalb Health Enterprises	100.00%	13,851		8
9	V	10 Nursing		Dekalb Health Enterprises	100.00%	4,753	4,753	9
10	V	21 Clerical		Dekalb Health Enterprises	100.00%	1,375	1,375	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 428,806			\$ 438,351	\$ * 9,545	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Insurance	\$ 2,861	CarePlus Helath Plans		\$ 2,861		15
16	V	19 Management - Operating	64,794	Tutera Health Care Services	100.00%	429,167	364,373	16
17	V	30 Management - Depreciation		Tutera Health Care Services	100.00%	8,149	8,149	17
18	V	26 Insurance	192,428	LTC Insurance, Inc		192,428		18
19	V	21 Asset Management Fee	100,000	JCT Capital LLC			(100,000)	19
20	V	21 Mangement Fee	362,810	Tutera Health Care Services	100.00%		(362,810)	20
21	V	21 Admin - Purchased Svs	151	Fair Oaks Rehab & HHC		151		21
22	V	21 Furniture/Postage/Small Equip	5,467	Walnut Creek Management		5,467		22
23	V	11 Activities Supplies	126	Walnut Creek Management		126		23
24	V	19 Data Processing/Legal	243	Walnut Creek Management		243		24
25	V	20 Employment Want Ads/Licenses/Dues	3,758	Walnut Creek Management		3,758		25
26	V	3 Housekeeping Purchased Svs	97	Walnut Creek Management		97		26
27	V	10 Nursing Supplies	126	Walnut Creek Management		126		27
28	V	32 Interest	267	JCT Capital LLC			(267)	28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 733,128			\$ 642,573	\$ * (90,555)	39

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

Facility Name & ID Number

Bethany Rehabilitation & Health Care Center

0048934

Report Period Beginning:

1/1/2018

Ending: 12/31/2018

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	JCT 6.1.98 Rev Trust	50%	Auburn Rehab & Health Care Center	Auburn, IL	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2	CMM 09 IDG Trust	16.67	Windsor Rehab & Health Care Center	Terrel, TX	Carnegie Village Senio	Belton, MO	IL/AL	2
3	MMC 09 IDG Trust	16.67	Carlinville Rehab & Health Care Center	Carlinville, IL	Continua Home Health	Kansas City, MO	Home Health	3
4	JCT 2009 IDG	16.66	Coulterville Rehab & Health Care Center	Coulterville, IL	Country Gardens Asst	Muskogee, OK	AL	4
5			Crystal Pines Rehab & Health Care Center	Crystal Lake, IL	Lamar Court Assisted	Overland Park, KS	AL	5
6			Dixon Rehab & Health Care Center	Dixon, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Fair Oaks Rehab & Health Care Center	South Beloit, IL	Rose Estates Assisted I	Overland Park, KS	AL	7
8			Hamilton Memorial Rehab & Health Care Center	McLeansboro IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Highland Rehav & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City, MO	IL/AL	9
10			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Wesley Court Assisted	Boiling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Asst. Liv	Laurinburg, NC	AL	11
12			Mattoon Rehab & Health Care Center	Mattoon, IL	Bright Oaks of Aurora	Aurora, IL	AL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Paradise Pak Assisted	Fox Lake, IL	AL	13
14			Metropolis Rehav & Health Care Center	Metropolis, IL	Dekalb Health Enterpr	Dekalb, IL	Building Company	14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LLC	Kansas City, MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Se	Kansas City, MO	Mgmt Company	16
17			Charlton Place Rehab & Health Care Center	Deatsville, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Westridge Gardens Rehab & Health Care Center	Raytown, MO	Walnut Creek Mgmt C	Kansas City, MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New En	Kansas City, MO	Mgmt Company	19
20			Holly Hill Rehab & Health Care Center	Sulphur, LA	LTC Plus Insurance, I	Kansas City, MO	Insurance Company	20
21			Rosewood Rehab & Health Care Center	Lake Charles, LA	Tutera Investments, In	Kansas City, MO	Mgmt Company	21
22			St. Paul's Senior Community	Belleville, IL	JCT Capital, Inc	Kansas City, MO	Mgmt Company	22
23			Greenfield Manor	Greenfield, IA	Tutera Group, Inc.	Kansas City, MO	Mgmt Company	23
24			Griswold Care Center	Griswold, IA	Residence at Pleasont	Pleasanton	AI/IL	24
25			Moweaqua Rehab & Health Care Center	Moweaqua, IL	Mt Ayr	Mt.Ayr, IA	AL/IL	25
26			Stratford Rehab & Health Care Center	Overland Park, KS	Missiona Chateua Sen	Prairie Village, KS	AL/IL	26
27			Carnegie Village Rehab & Health Care Center	Belton, MO				27
28			Tiffany Springs Rehab & Health Care Center	Kansas City, MO				28
29			Northland Rehab & Health Care Center	Kansas City, MO				29
30			Westview of Derby	Derby, KS				30

Facility Name & ID Number Bethany Rehabilitation & Health Care Cent # 0048934 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 761 State Line Road
 City / State / Zip Code Kansas City, Missouri 64114
 Phone Number (816) 444-0900
 Fax Number (816) 822-0081

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	Management Fee - Operating	Direct Cost	193,500,518	48	\$ 12,214,787	\$ 8,837,460	6,798,729	\$ 429,172	1
2	30	Management Fee - Depreciation	Direct Cost	193,500,518	48	231,947		6,798,729	8,150	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					\$ 12,446,734	\$ 8,837,460		\$ 437,322	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		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	HUD		X	Mortgage			\$	\$ 3,983,210			\$	116,377						
2	Interest Income Offset											(35,170)						
3	Amortize Financing Costs		X									9,196						
4																		
5																		
Working Capital																		
6	JCT Capital	X		Note Payable				81,206	207,973		0.0100	267						
7																		
8																		
9	TOTAL Facility Related						\$	81,206	\$ 4,191,183			\$ 90,670						
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$		\$			\$						
15	TOTALS (line 9+line14)						\$	81,206	\$ 4,191,183			\$ 90,670						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 20,220 Line # 36

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	123,521	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.)		\$	124,903	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,382	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	127,401	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	128,783	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	117,387	8	
	2014	117,326	9	
	2015	117,868	10	
	2016	123,522	11	
	2017	124,903	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethany Rehabilitation & Health Care Center COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0048934

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen, CPA

TELEPHONE (314) 925-4446 FAX #: (314) 925-4350

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>08-01357-006</u>	<u>Long-Term Care</u>	\$ <u>124,903.30</u>	\$ <u>124,903.30</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>124,903.30</u></u>	\$ <u><u>124,903.30</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Center

0048934

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Long-Term Care, 37,083, 1997, \$ 303,887, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 37,083, (blank), \$ 303,887, 3.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	90		1997	1997	\$ 3,401,350	\$ 85,034	40	\$ 85,034	\$	\$ 1,835,423
5										
6										
7										
8										
	Improvement Type**									
9		2009 Improvements (Bethany)		2009	4,929		5			4,929
10		2012 Improvements (Bethany)		2012	224,122	11,206	20	11,206		63,964
11		2013 Improvements (Bethany)		2013	39,433	5,633	7	5,633		19,074
12										
13		Home Office Allocation				8,149		8,149		
14										
15		1997 Improvements (Dekalb Enterprises)		1997	47,040	37	Various	37		46,365
16		1998 Improvements (Dekalb Enterprises)		1998	9,464		Various			9,464
17		1999 Improvements (Dekalb Enterprises)		1999	16,507		Various			16,507
18		2000 Improvements (Dekalb Enterprises)		2000	6,556		Various			6,556
19		2001 Improvements (Dekalb Enterprises)		2001	19,579		Various			19,579
20		2002 Improvements (Dekalb Enterprises)		2002	7,353		Various			7,353
21		2003 Improvements (Dekalb Enterprises)		2003	15,479	151	Various	151		14,750
22		2004 Improvements (Dekalb Enterprises)		2004	13,069	764	Various	764		12,433
23		2006 Improvements (Dekalb Enterprises)		2006	2,715		Various			2,715
24		2009 Improvements (Dekalb Enterprises)		2009	39,720	2,957	Various	2,957		35,677
25		2010 Improvements (Dekalb Enterprises)		2010	9,899	908	Various	908		7,869
26		2011 Improvements (Dekalb Enterprises)		2011	52,999	5,623	Various	5,623		50,881
27		2012 Improvements (Dekalb Enterprises)		2012	364,493	9,112	Various	9,112		56,952
28		Roof Top AC Unit (Dekalb Enterprises)		2014	8,238	824	10	824		3,638
29		Hallway Painting - Entire Facility (Dekalb Enterprises)		2015	40,615	2,708	15	2,708		9,251
30		Vinyl Tile & Cover Base - All Halls (Dekalb Enterprises)		2015	17,603	2,515	7	2,515		8,592
31		Ridge Cap Repalcement (Dekalb Enterprises)		2017	8,325	834	10	834		1,596
32		Parking Lot Improvements (Dekalb Enterprises)		2017	13,913	1,739	8	1,739		3,333
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	N/A		\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,363,401	\$ 138,194		\$ 138,194	\$	\$ 2,236,901	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 139,352	\$ 15,474	\$ 15,474	\$	Various	\$ 84,529	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	489,716	2,863	2,863		Various	489,716	73
74								74
75	TOTALS	\$ 629,068	\$ 18,337	\$ 18,337	\$		\$ 574,245	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2008 Passenger Ford E350	2008	\$ 45,874	\$	\$	\$	5	\$ 45,874	76
77										77
78										78
79										79
80	TOTALS			\$ 45,874	\$	\$	\$		\$ 45,874	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)	\$ 5,342,230	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 156,531	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 156,531	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)	\$ 2,857,020	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Center

0048934

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 9,373

Description: Copier, dishwasher laundry, plant, housekeeping (see WTB)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V39-03	hrs	\$	4,034	\$ 335,379	\$	4,034	\$ 335,379	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		630	3,706		630	3,706	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		4,850	430,662	693	4,850	431,355	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-02	# of prescrpts				215,500		215,500	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See WTB</u>					151,954	168,303		320,257	13
14	TOTAL			\$	9,514	\$ 921,701	\$ 384,496	9,514	\$ 1,306,197	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 Rehabilitation & Health Care Center# 0048934Report Period Beginning: 1/1/2018Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 283,878	\$ 316,462	1
2	Cash-Patient Deposits	19,776	19,776	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	544,386	544,386	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	146,681	168,334	6
7	Other Prepaid Expenses	449,186	449,186	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Current Assets</u>		130,296	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,443,907	\$ 1,628,440	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		303,887	13
14	Buildings, at Historical Cost	268,484	4,363,401	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	69,243	674,942	16
17	Accumulated Depreciation (book methods)	(151,828)	(2,857,020)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>WIP, PP&E Tax Adj</u>	128,959	(983,495)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 314,858	\$ 1,501,715	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,758,765	\$ 3,130,155	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 697,581	\$ 697,581	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,502	29,502	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	223,304	223,304	30
31	Accrued Taxes Payable (excluding real estate taxes)	47,413	47,413	31
32	Accrued Real Estate Taxes(Sch.IX-B)		127,401	32
33	Accrued Interest Payable		9,626	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 997,800	\$ 1,134,827	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	207,973	207,973	39
40	Mortgage Payable		3,743,483	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)	\$ 207,973	\$ 3,951,456	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,205,773	\$ 5,086,283	46
47	TOTAL EQUITY(page 18, line 24)	\$ 552,992	\$ (1,956,128)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,758,765	\$ 3,130,155	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 629,956	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 629,956	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	73,951	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	(150,915)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (76,964)	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)	\$ 552,992	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Bethany Rehabilitation & Health Care Center**# **0048934**Report Period Beginning: **1/1/2018**Ending: **12/31/2018****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required****classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,910,802	1
2	Discounts and Allowances for all Levels	(4,424,999)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,485,803	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,934,786	6
7	Oxygen	42,812	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,977,598	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,105	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	428,905	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	57,526	19
20	Radiology and X-Ray		20
21	Other Medical Services	301,932	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 791,468	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	35,170	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 35,170	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,890	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,890	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,291,929	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,030,964	31
32	Health Care	2,538,796	32
33	General Administration	1,623,526	33
B. Capital Expense			
34	Ownership	435,673	34
C. Ancillary Expense			
35	Special Cost Centers	1,411,751	35
36	Provider Participation Fee	177,268	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,217,978	40
41	Income before Income Taxes (line 30 minus line 40)**	73,951	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 73,951	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,145,970	44
45	Private Pay - Net Inpatient Revenue	905,977	45
46	Medicare - Net Inpatient Revenue	(1,162,249)	46
47	Other-(specify) Managed Care	(403,895)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,485,803	49

* 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 Rehabilitation & Health Care Center

0048934

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,758	1,997	\$ 91,546	\$ 45.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,553	32,203	960,737	29.83	3
4	Licensed Practical Nurses	12,752	13,594	397,111	29.21	4
5	CNAs & Orderlies	51,670	52,510	682,878	13.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	619	619	12,666	20.46	9
10	Activity Assistants	1,456	1,531	21,069	13.76	10
11	Social Service Workers	68,322	3,488	84,082	24.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,623	3,735	71,122	19.04	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,920	2,080	117,199	56.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,208	9,592	148,510	15.48	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	1,967	2,196	38,685	17.62	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	3,659	3,994	80,938	20.26	33
34	TOTAL (lines 1 - 33)	187,507	127,539	\$ 2,706,543 *	\$ 21.22	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	Monthly	\$ 353	V01-3	35
36	Medical Director	Monthly	11,000	V09-5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,256	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	47,245	V11-3	45
46	Other(specify)	Monthly	2,434	V12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 70,288		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	319	\$ 9,791	V10-3	50
51	Licensed Practical Nurses	312	13,517	V10-3	51
52	Certified Nurse Assistants/Aides	146	4,700	V10-3	52
53	TOTAL (lines 50 - 52)	777	\$ 28,008		53

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	
Brian Thor	Adminstrator	0	\$ 117,199	Workers' Compensation Insurance	\$ 61,145	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	4,272	
				FICA Taxes	225,679	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	59,254	Patient Background Checks	108	
				Employee Meals			1,081	
				Illinois Municipal Retirement Fund (IMRF)*		IL Health Care Association	7,925	
				Other Benefits	9,452	Subscriptions	100	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 117,199			Other Licenses	1,444	
B. Administrative - Other						Less: Public Relations Expense	(2,982)	
Description			Amount			Non-allowable advertising (
N/A			\$			Yellow page advertising (
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 355,530	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,830	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Daniel Maher Law Offices	Legal		\$ 2,120	N/A		\$	Out-of-State Travel	\$
Hamlin & Burton Liabilty Managemc	Legal		2,772					
Heyl Royster Voelker & Allen	Legal		7,332					
Other Accrual	Legal		25,554				In-State Travel	2,172
CliftonLarsonAllen LLP	Accounting/Cost Report		15,660					
Walnut Creek Mgmt Co, LLC	Data Processing		67,179					
Ability Network Inc	Data Processing		1,591				Seminar Expense	
PointClickCare Technologies	Data Processing		26,936					
Allscripts Healthcare LLC	Professional Services		2,280					
Pinnacle Quality Insight	Professional Services		1,396					
Property Valuation Services	Professional Services		100				Entertainment Expense (
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 152,920	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,172

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Health Care Association, \$5,940
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,210 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. \$ 177,268
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,105
- (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? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100%
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees