



Facility Name & ID Number Bethany Rehabilitation & Health Care Center

# 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	13,571	4,072	9,623	27,266	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	13,571	4,072	9,623	27,266	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.00%

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

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

F. Does the facility maintain a daily midnight census? 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 01/28/1998

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 01/28/1998 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 6,634

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Cente # 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

**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		14,620	561,385	576,005	576,005		576,005			1
2	Food Purchase		3,853		3,853	3,853	(3,508)	345			2
3	Housekeeping		11,731	102,955	114,686	114,686		114,686			3
4	Laundry		8,435	68,246	76,681	76,681		76,681			4
5	Heat and Other Utilities			125,243	125,243	125,243	2,200	127,443			5
6	Maintenance	74,784	10,446	97,965	183,195	183,195	3,319	186,514			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	74,784	49,085	955,794	1,079,663	1,079,663	2,011	1,081,674			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,000	10,000	10,000		10,000			9
10	Nursing and Medical Records	2,088,509	146,825	5,601	2,240,935	2,240,935	47,403	2,288,338			10
10a	Therapy										10a
11	Activities	104,266	23,867	2,976	131,109	131,109		131,109			11
12	Social Services	166,647		2,848	169,495	169,495		169,495			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*						12,416	12,416			15
16	<b>TOTAL Health Care and Programs</b>	2,359,422	170,692	21,425	2,551,539	2,551,539	59,820	2,611,359			16
	<b>C. General Administration</b>										
17	Administrative	100,126		390,884	491,010	491,010	(390,844)	100,166			17
18	Directors Fees										18
19	Professional Services			139,317	139,317	(100)	139,217	94,645			19
20	Dues, Fees, Subscriptions & Promotions			56,604	56,604		56,604	17,287			20
21	Clerical & General Office Expenses	158,498	31,558	345,207	535,263	535,263	(65,642)	469,621			21
22	Employee Benefits & Payroll Taxes			321,566	321,566	321,566		321,566			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,903	1,903	1,903	5,209	7,112			24
25	Other Admin. Staff Transportation			6,736	6,736	6,736	17,940	24,676			25
26	Insurance-Prop.Liab.Malpractice			172,236	172,236	172,236	2,029	174,265			26
27	Other (specify):*						39,731	39,731			27
28	<b>TOTAL General Administration</b>	258,624	31,558	1,434,453	1,724,635	(100)	1,724,535	1,249,070			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,692,830	251,335	2,411,672	5,355,837	(100)	5,355,737	4,942,103			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 Rehabilitation & Health Care Center #0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			15,531	15,531		15,531	181,632	197,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,290	1,290		1,290	166,324	167,614			32
33	Real Estate Taxes			110,400	110,400	100	110,500	1,218	111,718			33
34	Rent-Facility & Grounds			329,071	329,071		329,071	(323,686)	5,385			34
35	Rent-Equipment & Vehicles			14,544	14,544		14,544	3,399	17,943			35
36	Other (specify):*							21,403	21,403			36
37	<b>TOTAL Ownership</b>			470,836	470,836	100	470,936	50,289	521,225			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		454,681	1,060,770	1,515,451		1,515,451		1,515,451			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,463	174,463		174,463		174,463			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		454,681	1,235,233	1,689,914		1,689,914		1,689,914			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,692,830	706,016	4,117,741	7,516,587		7,516,587	(363,345)	7,153,242			45

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



Bethany Rehabilitation & Health Care Center

ID# 0048934

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Machine Revenue	\$ (35)	02	1
2	Professional Fees Refund	(85)	19	2
3	RP Asset Management Fees	(204,000)	21	3
4	PAC Dues	(2,400)	20	4
5	Building Co. - Legal Fees	(2,228)	19	5
6	Building Co. - Accounting Fees	(8,208)	19	6
7	Building Co. - Amortization	(1,692)	36	7
8	Chamber of Commerce	(2,557)	20	8
9	Building Company - Other Taxes	(2,162)	20	9
10	Non Allowable Travel	(5,159)	25	10
11	Marketing Seminar	(157)	24	11
12	Non Allowable Legal	(200)	19	12
13	Building Co - R&M	1,933	06	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	<b>Total</b>	(226,950)		49

Bethany Rehabilitation & Health Care Center

Report Period Beginning:                     01/01/15                      
 Ending:   12/31/15  

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

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(3,508)											(3,508)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				2,200								2,200	5
6	Maintenance	1,933			1,386								3,319	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(1,575)</b>			<b>3,587</b>								<b>2,011</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			47,403									47,403	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			12,416									12,416	15
16	<b>TOTAL Health Care and Programs</b>			<b>59,820</b>									<b>59,820</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(390,844)									(390,844)	17
18	Directors Fees													18
19	Professional Services	(10,721)	10,436	(44,326)	39								(44,572)	19
20	Fees, Subscriptions & Promotions	(40,027)		709									(39,317)	20
21	Clerical & General Office Expenses	(272,992)	2,162	205,179	9								(65,642)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(157)		5,367									5,209	24
25	Other Admin. Staff Transportation	(5,159)		23,099									17,940	25
26	Insurance-Prop.Liab.Malpractice			1,928	101								2,029	26
27	Other (specify):*			39,731									39,731	27
28	<b>TOTAL General Administration</b>	<b>(329,056)</b>	<b>12,598</b>	<b>(159,156)</b>	<b>149</b>								<b>(475,465)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(330,631)</b>	<b>12,598</b>	<b>(99,336)</b>	<b>3,736</b>								<b>(413,634)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethany Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	50,479	123,888	5,243	2,022								181,632	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(737)	166,862		199								166,324	32
33	Real Estate Taxes			82	1,136								1,218	33
34	Rent-Facility & Grounds		(323,686)	9,054	(9,054)								(323,686)	34
35	Rent-Equipment & Vehicles			3,399									3,399	35
36	Other (specify):*	(1,692)	23,095										21,403	36
37	<b>TOTAL Ownership</b>	<b>48,050</b>	<b>(9,841)</b>	<b>17,777</b>	<b>(5,697)</b>								<b>50,289</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													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>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(282,581)</b>	<b>2,757</b>	<b>(81,560)</b>	<b>(1,961)</b>								<b>(363,345)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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)		
1	V	34 Rent	\$ 323,686	DeKalb Health Enterprises, Inc.	100.00%	\$	(323,686)	1	
2	V	32 Interest	93	DeKalb Health Enterprises, Inc.	100.00%	166,955	166,862	2	
3	V	19 Legal Fees		DeKalb Health Enterprises, Inc.	100.00%	2,228	2,228	3	
4	V	19 Accounting Fees		DeKalb Health Enterprises, Inc.	100.00%	8,208	8,208	4	
5	V	21 Other Taxes		DeKalb Health Enterprises, Inc.	100.00%	2,162	2,162	5	
6	V	36 Mortgage Insurance Premium		DeKalb Health Enterprises, Inc.	100.00%	21,403	21,403	6	
7	V	30 Depreciation		DeKalb Health Enterprises, Inc.	100.00%	123,888	123,888	7	
8	V	36 Amortization		DeKalb Health Enterprises, Inc.	100.00%	1,692	1,692	8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 323,779			\$ 326,536	\$ *	2,757	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	10 NURSING & MEDICAL RECORDS		Tutera Health Care Services	100.00%	161	\$ 161
16	V	10 NURSING SALARIES		Tutera Health Care Services	100.00%	47,242	47,242
17	V	15 NURSING TAXES & BENEFITS		Tutera Health Care Services	100.00%	12,416	12,416
18	V	19 PROFESSIONAL FEES	48,000	Tutera Health Care Services	100.00%	3,674	(44,326)
19	V	20 DUES, FEES, LICENSES, MEMBERSHIPS		Tutera Health Care Services	100.00%	709	709
20	V	21 OFFICE EXPENSES		Tutera Health Care Services	100.00%	21,073	21,073
21	V	21 OFFICE SALARIES		Tutera Health Care Services	100.00%	184,106	184,106
22	V	24 BUSINESS SEMINAR		Tutera Health Care Services	100.00%	5,367	5,367
23	V	25 TRAVEL EXPENSES		Tutera Health Care Services	100.00%	23,099	23,099
24	V	26 INSURANCE		Tutera Health Care Services	100.00%	1,928	1,928
25	V	27 EMP BENEFITS & PAYROLL TAXES		Tutera Health Care Services	100.00%	39,731	39,731
26	V	30 DEPRECIATION		Tutera Health Care Services	100.00%	5,243	5,243
27	V	33 REAL ESTATE TAXES		Tutera Health Care Services	100.00%	82	82
28	V	34 RENTAL OF SPACE		Tutera Health Care Services	100.00%	9,054	9,054
29	V	35 EQUIPMENT RENTAL		Tutera Health Care Services	100.00%	549	549
30	V	35 AUTO RENTAL		Tutera Health Care Services	100.00%	2,849	2,849
31	V						
32	V	17 MANAGEMENT FEES	390,844	Tutera Health Care Services	100.00%		(390,844)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 438,844			\$ 357,284	\$ * (81,560)

\* 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	5 UTILITIES	\$	Columbia 7611, LLC	100.00%	\$ 2,200	\$ 2,200
16	V	6 REPAIRS, MAINTENANCE & SECURITY		Columbia 7611, LLC	100.00%	1,386	1,386
17	V	19 PROFESSIONAL FEES		Columbia 7611, LLC	100.00%	39	39
18	V	21 OFFICE EXPENSES		Columbia 7611, LLC	100.00%	9	9
19	V	26 INSURANCE		Columbia 7611, LLC	100.00%	101	101
20	V	30 DEPRECIATION		Columbia 7611, LLC	100.00%	2,022	2,022
21	V	32 INTEREST EXPENSE		Columbia 7611, LLC	100.00%	199	199
22	V	33 REAL ESTATE TAXES		Columbia 7611, LLC	100.00%	1,136	1,136
23	V						
24	V	34 RENT	9,054	Columbia 7611, LLC	100.00%		(9,054)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,054			\$ 7,093	\$ * (1,961)

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name &amp; ID Number

Bethany Rehabilitation &amp; Health Care Center

# 0048934

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	Joseph Tintera	50%	Auburn Rehabilitation & Health Care Center	Auburn, IL	DeKalb Health Enterprises	Dekalb, IL	Building Company	1
2	Lucille Tintera	50%	Windsor Rehabilitation & Health Care Center	Terrell, TX	Walnut Creek Management Compa	Kansas City, MO	Management Co	2
3			Carlville Rehabilitation & Health Care Center	Carlville, IL	Tutera Health Care Services, LLC	Kansas City, MO	Management Co	3
4			Crystal Pines Rehabilitation & Health Care Center	Crystal Lake, IL	LTC Services, LLC	Kansas City, MO	Management Co	4
5			Dixon Rehabilitation & Health Care Center	Dixon, IL	Walnut Creek- New England, LLC	Kansas City, MO	Management Co	5
6			Fair Oaks Rehabilitation & Health Care Center	South Beloit, IL	Columbia 7611 LLC	Kansas City, MO	Building Company	6
7			Hamilton Memorial Rehabilitation & Health Care Center	McLeansboro, IL	The Atriums Senior Living Commu	Overland Park, KS	Independent/Assisted Living	7
8			Highland Rehabilitation & Health Care Center	Kansas City, MO	Carnegie Village Senior Living Con	Belton, MO	Independent/Assisted Living	8
9			Hillsboro Rehabilitation & Health Care Center	Hillsboro, IL	Continua Home Health	Kansas/Missouri	Home Health	9
10			Lakeland Rehabilitation & Health Care Center	Effingham, IL	Continua Hospice KS	Kansas	Hospice	10
11			Mattoon Rehabilitation & Health Care Center	Mattoon, IL	Continua Hospice MO	Missouri	Hospice	11
12			Meridian Rehabilitation & Health Care Center	Wichita, KS	Country Gardens Assisted Living C	Muskogee, OK	Assisted Living	12
13			Metropolis Rehabilitation & Health Care Center	Metropolis, IL	Gentilly Gardens Senior Living Cor	Statesboro, GA	Assisted Living	13
14			Monterey Park Rehabilitation & Health Care Center	Independence, MO	Lamar Court Assisted Living Comr	Overland Park, KS	Assisted Living	14
15			Montgomery Children's Specialty Center	Montgomery, AL	Oakley Courts Assisted Living Com	Freeport, IL	Assisted Living	15
16			Moweaqua Rehabilitation & Health Care Center	Moweaqua, IL	Rose Estates Assisted Living Comm	Overland Park, KS	Assisted Living	16
17			The Pine Rehabilitation & Health Care Center	Lansing, MI	Stratford Commons Memory Care	Overland Park, KS	Memory Care	17
18			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Victory Hills Senior Living Commu	Kansas City, KS	Independent/Assisted Living	18
19			Charlton Place Rehabilitation & Health Care Center	Deatsville, AL	Wesley Court Assisted Living Com	Boiling Springs, SC	Assisted Living	19
20			Stratford Commons Rehabilitation & Health Care Center	Overland Park, KS	Willow Place Assisted Living & Me	Laurinburg, NC	Assisted Living	20
21			Westridge Gardens Rehabilitation & Health Care Center	Raytown, MO				21
22			Willow Care Rehabilitation & Health Care Center	Hannibal, MO				22
23			Woodlawn Rehabilitation & Health Care Center	Wichita, KS				23
24			Holly Hill House	Sulphur, LA				24
25			Rosewood Nursing Center	Lake Charles, LA				25
26			Beautiful Savior	Belton, MO				26
27			Coulterville Rabilitation & Health Care Center	Coulterville, IL				27
28			Greenfield Manor	Greenfield, IA				28
29			Griswold Care Center	Griswold, IA				29
30			Close to Home	Matthews, MO				30



Facility Name & ID Number Bethany Rehabilitation & Health Care Cent # 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										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: 01/01/15 Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Center

# 0048934

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Tutera Health Care Services  
 Street Address 7611 State Line Road  
 City / State / Zip Code Kansas City, Missouri 64114  
 Phone Number (816) 444-0900  
 Fax Number (816) 822-0081

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

1	2	3	4	5	6	7	8	9	
Schedule V	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	
Line Reference									
1	10	NURSING & MEDICAL RECOR	OPERATING EXPENSE	167,826,743	38	3,889	6,968,527	161	1
2	10	NURSING SALARIES	OPERATING EXPENSE	167,826,743	38	1,137,749	6,968,527	47,242	2
3	15	NURSING TAXES & BENEFITS	OPERATING EXPENSE	167,826,743	38	299,032	6,968,527	12,416	3
4	19	PROFESSIONAL FEES	OPERATING EXPENSE	167,826,743	38	88,474	6,968,527	3,674	4
5	20	DUES, FEES, LICENSES, MEME	OPERATING EXPENSE	167,826,743	38	17,081	6,968,527	709	5
6	21	OFFICE EXPENSES	OPERATING EXPENSE	167,826,743	38	507,506	6,968,527	21,073	6
7	21	OFFICE SALARIES	OPERATING EXPENSE	167,826,743	38	4,433,923	6,968,527	184,106	7
8	24	BUSINESS SEMINAR	OPERATING EXPENSE	167,826,743	38	129,254	6,968,527	5,367	8
9	25	TRAVEL EXPENSES	OPERATING EXPENSE	167,826,743	38	556,315	6,968,527	23,099	9
10	26	INSURANCE	OPERATING EXPENSE	167,826,743	38	46,444	6,968,527	1,928	10
11	27	EMP BENEFITS & PAYROLL T	OPERATING EXPENSE	167,826,743	38	956,875	6,968,527	39,731	11
12	30	DEPRECIATION	OPERATING EXPENSE	167,826,743	38	126,260	6,968,527	5,243	12
13	33	REAL ESTATE TAXES	OPERATING EXPENSE	167,826,743	38	1,969	6,968,527	82	13
14	34	RENTAL OF SPACE	OPERATING EXPENSE	167,826,743	38	218,043	6,968,527	9,054	14
15	35	EQUIPMENT RENTAL	OPERATING EXPENSE	167,826,743	38	13,230	6,968,527	549	15
16	35	AUTO RENTAL	OPERATING EXPENSE	167,826,743	38	68,623	6,968,527	2,849	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 8,604,665	\$ 5,571,671	\$ 357,284	25

Facility Name & ID Number Bethany Rehabilitation & Health Care Center

# 0048934

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 Columbia 7611, LLC  
 Street Address 7611 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	5	UTILITIES	OPERATING EXPENSE 167,826,743	38	\$ 52,990	\$	6,968,527	\$ 2,200	1
2	6	REPAIRS, MAINTENANCE & S	OPERATING EXPENSE 167,826,743	38	33,391		6,968,527	1,386	2
3	19	PROFESSIONAL FEES	OPERATING EXPENSE 167,826,743	38	942		6,968,527	39	3
4	21	OFFICE EXPENSES	OPERATING EXPENSE 167,826,743	38	220		6,968,527	9	4
5	26	INSURANCE	OPERATING EXPENSE 167,826,743	38	2,422		6,968,527	101	5
6	30	DEPRECIATION	OPERATING EXPENSE 167,826,743	38	48,695		6,968,527	2,022	6
7	32	INTEREST EXPENSE	OPERATING EXPENSE 167,826,743	38	4,794		6,968,527	199	7
8	33	REAL ESTATE TAXES	OPERATING EXPENSE 167,826,743	38	27,363		6,968,527	1,136	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				\$ 170,817	\$		\$ 7,093	25

Facility Name & ID Number Bethany Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Center

# 0048934

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

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

Facility Name & ID Number Bethany Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

Facility Name &amp; ID Number

Bethany Rehabilitation &amp; Health Care Center

# 0048934

Report Period Beginning:

01/01/15

Ending:

12/31/15

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
	<b>A. Directly Facility Related</b>																				
	<b>Long-Term</b>																				
1	HUD		X	Mortgage			\$	\$ 4,246,646			\$ 166,955	1									
2												2									
3												3									
4												4									
5												5									
	<b>Working Capital</b>																				
6	TGI		X	Note Payable				454,069			1,290	6									
7	Allocated from Columbia 7611 LLC		X								199	7									
8												8									
9	TOTAL Facility Related						\$	\$ 4,700,715			\$ 168,445	9									
	<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(737)	10									
11	Interest Income - Bldg. Co		X								(93)	11									
12												12									
13												13									
14	TOTAL Non-Facility Related						\$	\$			\$ (830)	14									
15	TOTALS (line 9+line14)						\$	\$ 4,700,715			\$ 167,615	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,403 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.)

Facility Name & ID Number Bethany Rehabilitation & Health Care Center # 0048934 Report Period Beginning: 01/01/15 Ending: 12/31/15

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									20										

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

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																						
1. Real Estate Tax accrual used on 2014 report.		\$	<b>102,505</b>	<b>1</b>																				
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.)		\$	<b>118,544</b>	<b>2</b>																				
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>16,039</b>	<b>3</b>																				
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>95,579</b>	<b>4</b>																				
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>100</b>	<b>5</b>																				
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>111,718</b>	<b>7</b>																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2010	<u>107,676</u>	<u>8</u>	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;"><b>13</b></td> <td>FROM R. E. TAX STATEMENT FOR 2014</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>13</b></td> </tr> <tr> <td style="text-align: center;"><b>14</b></td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>14</b></td> </tr> <tr> <td style="text-align: center;"><b>15</b></td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>15</b></td> </tr> <tr> <td style="text-align: center;"><b>16</b></td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>16</b></td> </tr> </table>		<b>FOR BHF USE ONLY</b>			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2014	\$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>
<b>FOR BHF USE ONLY</b>																								
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2014	\$	<b>13</b>																					
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>																					
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>																					
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>																					
	2011	<u>112,209</u>	<u>9</u>																					
	2012	<u>114,924</u>	<u>10</u>																					
	2013	<u>117,387</u>	<u>11</u>																					
	2014	<u>117,326</u>	<u>12</u>																					
<b>2015 Accrual: \$117,326 x 0.81 = \$95,579</b>																								
<b>Allocated from Columbia 7611 LLC: \$1,136</b>																								
<b>Allocated from Tutera HC Services: \$81</b>																								

**NOTES:**

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





**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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1997</u>	<u>\$ 303,889</u>	<u>1</u>
2	<u>Allocated from Columbia 7611, LLC</u>			<u>4,670</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 308,559</b>	<b>3</b>

**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	\$ 3,353,760	\$ 123,888	40	\$ 83,844	\$ (40,044)	\$ 1,622,624	4
5			1997	1997	41,145						5
6			1997	1997	2,534						6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2009		4,929		20	246	246	4,600	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

\*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

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# 0048934

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**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		503,616			24,681	24,681	142,721	67
68		51,194	1,997		1,567	(430)	37,620	68
69			15,531			(15,531)		69
70		\$ 3,957,178	\$ 141,416		\$ 110,338	\$ (31,078)	\$ 1,807,565	70

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

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**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,957,178	\$ 141,416		\$ 110,338	\$ (31,078)	\$ 1,807,565	1
2	200 Hall Renovations- Part 1	2012	157,384		20	11,206	11,206	34,552	2
3	Settlement Reduction	2012	(9,354)		20				3
4	100 Hall Bathing Rms/Shower - Flooring, Tile Base, Grab Bars, Pa	2013	36,925		20	1,972	1,972	5,915	4
5	Soft Water Conditioner	2014	7,732		20	387	387	773	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,149,865	\$ 141,416		\$ 123,903	\$ (17,514)	\$ 1,848,806	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,149,865	\$ 141,416		\$ 123,903	\$ (17,514)	\$ 1,848,806	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 4,149,865	\$ 141,416		\$ 123,903	\$ (17,514)	\$ 1,848,806	34

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

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**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,149,865	\$ 141,416		\$ 123,903	\$ (17,514)	\$ 1,848,806	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,149,865	\$ 141,416		\$ 123,903	\$ (17,514)	\$ 1,848,806	34

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

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**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,149,865	\$ 141,416		\$ 123,903	\$ (17,514)	\$ 1,848,806	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 4,149,865	\$ 141,416		\$ 123,903	\$ (17,514)	\$ 1,848,806	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9									9
10	Various	1998	3,086		20	154	154	2,777	10
11	Various	1999	16,507		20	825	825	14,031	11
12	Various	2000	6,556		20	328	328	5,245	12
13	Various	2001	14,405		20	720	720	10,804	13
14	Various	2002	4,551		20	228	228	3,186	14
15	Various	2003	15,479		20	774	774	10,061	15
16	Various	2004	13,069		20	653	653	7,841	16
17	Various	2006	2,715		20	136	136	1,358	17
18	Various	2008	9,620		20	481	481	3,848	18
19	Air Conditioner Digismart	2010	5,058		20	253	253	1,517	19
20	Door Closers	2010	7,700		20	385	385	2,310	20
21	Wireless Infrastructuire And Wiring	2010	19,709		20	485	485	2,913	21
22	Call light system	2011	12,430		20	622	622	3,108	22
23	200 Hall Renovations- Part 2	2012	364,493		20	18,225	18,225	72,899	23
24	Roof Top Unit	2014	8,238		20	412	412	824	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 503,616	\$		\$ 24,681	\$ 24,681	\$ 142,721	34

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

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**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 503,616	\$		\$ 24,681	\$ 24,681	\$ 142,721	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 503,616	\$		\$ 24,681	\$ 24,681	\$ 142,721	34

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

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01/01/15

Ending:

12/31/15

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Columbia 7611, LLC	1989	40,382	1,607	35	1,154	(453)	31,152	3
4	Allocated from Columbia 7611, LLC	1990	4,620	184	35	132	(52)	3,432	4
5	Allocated from Columbia 7611, LLC	1991	610	24	35	17	(7)	436	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Columbia 7611, LLC	1989	22		20			22	9
10	Allocated from Columbia 7611, LLC	1994	115	4	20		(4)	115	10
11	Allocated from Columbia 7611, LLC	1995	178	6	20		(6)	178	11
12	Allocated from Columbia 7611, LLC	1996	331	6	20	17	11	331	12
13	Allocated from Columbia 7611, LLC	2003	128	4	20	6	2	84	13
14	Allocated from Columbia 7611, LLC	2006	625		20	31	31	313	14
15	Allocated from Columbia 7611, LLC	2008	987	32	20	49	17	395	15
16	Allocated from Columbia 7611, LLC	2011	274	9	20	14	5	69	16
17									17
18	Allocated from LTC Services LLC	2001	71		20	4	4	53	18
19	Allocated from LTC Services LLC	2002	66		20	3	3	46	19
20									20
21	Allocated from Walnut Creek Management	2006	1,753		20	88	88	876	21
22	Allocated from Walnut Creek Management	2007	42		20	2	2	19	22
23	Allocated from Walnut Creek Management	2014	990	121	20	50	(71)	99	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 51,194	\$ 1,997		\$ 1,567	\$ (430)	\$ 37,620	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 51,194	\$ 1,997		\$ 1,567	\$ (430)	\$ 37,620	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 51,194	\$ 1,997		\$ 1,567	\$ (430)	\$ 37,620	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 727,792	\$ 4,874	\$ 72,348	\$ 67,474	10	\$ 304,395	71
72	Current Year Purchases	7,025	61	703	642	10	703	72
73	Fully Depreciated Assets	12,185	146		(146)	10	12,185	73
74								74
75	TOTALS	\$ 747,002	\$ 5,081	\$ 73,051	\$ 67,970		\$ 317,283	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 10 Passenger For E-350 Van	2008	\$ 45,874	\$	\$	\$	5	\$ 45,874	76
77		Allocated from LTC Services LLC	2015	1,658				5	1,658	77
78		Allocated from Walnut Creek Ma	2015	4,453	186	209	23	5	4,244	78
79										79
80	TOTALS			\$ 51,985	\$ 186	\$ 209	\$ 23		\$ 51,776	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)	\$ 5,257,411	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 146,683	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 197,162	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 50,479	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,217,865	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.

**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?  YES  NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage Rental				5,385			5
6								6
7	TOTAL				\$ 5,385			7

\*\*

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

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

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

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 15,093 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Tutera HC Services		\$	\$ 2,849	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,849	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

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

12. /2016 \$ \_\_\_\_\_

13. /2017 \$ \_\_\_\_\_

14. /2018 \$ \_\_\_\_\_

\* 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		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 345,669	\$		\$ 345,669	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			120,584			120,584	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			542,343	1,390		543,733	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				298,516		298,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <b>See Supplemental</b>					52,174	154,775		206,949	13
14	<b>TOTAL</b>			\$		\$ 1,060,770	\$ 454,681		\$ 1,515,451	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**# **0048934**Report Period Beginning: **01/01/15**

Ending:

**12/31/15****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/15**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 276,539	\$ 297,289	1
2	Cash-Patient Deposits	17,006	17,006	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,501,547	1,501,547	3
4	Supply Inventory (priced at )	11,092	11,092	4
5	Short-Term Investments			5
6	Prepaid Insurance	131,724	126,676	6
7	Other Prepaid Expenses	24,583	40,424	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	78,309	247,154	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,040,800	\$ 2,241,188	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		4,009,870	14
15	Leasehold Improvements, at Historical Cost	268,484	273,074	15
16	Equipment, at Historical Cost	63,743	643,249	16
17	Accumulated Depreciation (book methods)	(103,453)	(2,419,972)	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):	129,262	110,504	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 358,036	\$ 2,920,614	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,398,836	\$ 5,161,802	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 566,073	\$ 566,072	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,202	9,202	28
29	Short-Term Notes Payable	454,069	454,069	29
30	Accrued Salaries Payable	253,939	253,939	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,541	48,541	31
32	Accrued Real Estate Taxes(Sch.IX-B)	109,492	95,579	32
33	Accrued Interest Payable		13,802	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule	55,680	55,680	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,496,996	\$ 1,496,884	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,246,646	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>	\$	\$ 4,246,646	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,496,996	\$ 5,743,530	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 901,840	\$ (581,728)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,398,836	\$ 5,161,802	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>699,004</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prepaid Taxes/Distributions</b>	<b>(109,369)</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>589,635</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>312,205</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>312,205</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>901,840</b>	<b>24</b> *

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

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

# 0048934

Report Period Beginning: 01/01/15

Ending:

12/31/15

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,529,014	1
2	Discounts and Allowances for all Levels	(1,183,960)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,345,054	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,455,795	6
7	Oxygen	47,157	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,502,952	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	626,526	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,846	19
20	Radiology and X-Ray		20
21	Other Medical Services	306,557	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 979,929	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	737	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 737	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	120	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 120	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,828,792	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,079,663	31
32	Health Care	2,551,539	32
33	General Administration	1,724,635	33
<b>B. Capital Expense</b>			
34	Ownership	470,836	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,515,451	35
36	Provider Participation Fee	174,463	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,516,587	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	312,205	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 312,205	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,051,022	44
45	Private Pay - Net Inpatient Revenue	833,136	45
46	Medicare - Net Inpatient Revenue	1,068,493	46
47	Other-(specify) <u>Insurance</u>	392,403	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,345,054	49

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

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

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

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

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

# **0048934**

Report Period Beginning:

**01/01/15**

Ending:

**12/31/15**

**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	7,923	8,714	\$ 304,658	\$ 34.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,971	32,893	871,652	26.50	3
4	Licensed Practical Nurses	4,125	4,533	127,414	28.11	4
5	CNAs & Orderlies	56,267	58,794	730,970	12.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,847	8,409	104,266	12.40	10
11	Social Service Workers	7,158	7,813	166,647	21.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,087	4,375	74,784	17.09	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,032	2,169	100,126	46.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,007	8,681	158,498	18.26	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	1,928	2,252	35,286	15.67	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,075	1,142	18,529	16.23	33
34	TOTAL (lines 1 - 33)	131,420	139,775	\$ 2,692,830 *	\$ 19.27	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	\$ 561,385	01-03	35
36	Medical Director	Monthly	10,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,601	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,976	11-03	44
45	Social Service Consultant	Monthly	2,848	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 582,810		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

**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	
Anthony Valentino	Administrator	0	\$ 50,864	Workers' Compensation Insurance	\$ 68,851	IDPH License Fee	\$	
Richard Rimkus	Administrator	0	49,262	Unemployment Compensation Insurance		Advertising: Employee Recruitment	492	
				FICA Taxes	206,001	Health Care Worker Background Check		
				Employee Health Insurance	42,771	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	2,440	
				Other Employee Benefits	3,942	Dues & Subscriptions	5,847	
						Employment Expense	7,798	
TOTAL (agree to Schedule V, line 17, col. 1)						Allocated from Tutera HC Services	709	
(List each licensed administrator separately.)			\$ 100,126					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 321,565	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
Tutera Health Care Management			\$ 390,884			\$ 17,285		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 390,884					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
FR&R/Marcum LLP	Accounting Services	\$ 9,117			\$	Out-of-State Travel	\$	
Wescom Solutions Inc	Data Processing	16,634						
Tutera Health Care Services	Data Processing	48,000						
Kronos	Data Processing	27,516				In-State Travel		
E-Health Data Solutions	Data Processing	8,778						
Pinnacle Quality Insight	Customer Satisfaction	1,848						
See Attached	Legal Fees	25,061						
Thomas & Company	Unemployment Consultant	860				Seminar Expense	1,746	
Property Valuation Services	RE Assessment	100				Allocated from Tutera HC Services	5,367	
Beagle Parent Corp & Subs	Data Processing	351						
HealthLink	Professional Services	1,052						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		Entertainment Expense	( )	
(For legal fee disclosure, see page 39 of instructions)			\$ 139,316			(agree to Sch. V, line 24, col. 8)		
						TOTAL	\$ 7,113	

\* Attach copy of IMRF notifications

\*\*See instructions.



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

Report Period Beginning:

01/01/15

Ending:

12/31/15**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 \$6,372
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,529 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. \$ 174,463  
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? 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.