FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0012229

Facility Name: Bethesda Rehab & Senior Care

Address: 2833 N. Nordica Ave. (Number) Chicago (City) 60634 (Zip Code)

County: Cook

Telephone Number: (773) 622-6144 **Fax #** (773) 622-8261

HFS ID Number:

Date of Initial License for Current Owners: 6/6/1959

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,410	3
4		Intermediate/DD			4
5	39	Sheltered Care (SC)	39	14,235	5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,100	3,602	9,372	16,074	8
9	SNF/PED					9
10	ICF	6,005	1,706	2,562	10,273	10
11	ICF/DD					11
12	SC		6,418		6,418	12
13	DD 16 OR LESS					13
14	TOTALS	9,105	11,726	11,934	32,765	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.49%

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)
Adult Day Care

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1925

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 62 and days of care provided 4,135

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	371,323	76,885	215,637	663,845		663,845		663,845			1
2	Food Purchase		284,602		284,602		284,602	(1,784)	282,818			2
3	Housekeeping	194,272	96,696		290,968		290,968		290,968			3
4	Laundry		1,094	69,202	70,296		70,296		70,296			4
5	Heat and Other Utilities			188,260	188,260		188,260	(6,189)	182,071			5
6	Maintenance	171,381	93	255,705	427,179		427,179	34,468	461,647			6
7	Other (specify):*											7
8	**TOTAL General Services**	736,976	459,370	728,804	1,925,150		1,925,150	26,495	1,951,645			8
	B. Health Care and Programs											
9	Medical Director			8,038	8,038		8,038		8,038			9
10	Nursing and Medical Records	3,116,317	101,080	104,824	3,322,221		3,322,221	(34)	3,322,187			10
10a	Therapy		840	188	1,028		1,028		1,028			10a
11	Activities	161,858	36,160	920	198,938		198,938		198,938			11
12	Social Services	193,951	377	12,000	206,328		206,328		206,328			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,472,126	138,457	125,970	3,736,553		3,736,553	(34)	3,736,519			16
	C. General Administration											
17	Administrative	312,712		347,974	660,686		660,686		660,686			17
18	Directors Fees											18
19	Professional Services			200,898	200,898		200,898	(653)	200,245			19
20	Dues, Fees, Subscriptions & Promotions			74,084	74,084		74,084	(34,485)	39,599			20
21	Clerical & General Office Expenses	172,500	24,512	212,560	409,572		409,572	(148,190)	261,382			21
22	Employee Benefits & Payroll Taxes			915,528	915,528		915,528	(7,900)	907,628			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,481	17,481		17,481		17,481			24
25	Other Admin. Staff Transportation			1,785	1,785		1,785		1,785			25
26	Insurance-Prop.Liab.Malpractice			139,401	139,401		139,401		139,401			26
27	Other (specify):*											27
28	**TOTAL General Administration**	485,212	24,512	1,909,711	2,419,435		2,419,435	(191,228)	2,228,207			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,694,314	622,339	2,764,485	8,081,138		8,081,138	(164,767)	7,916,371			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 Bethesda Rehab & Senior Care #0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			673,630	673,630		673,630	45,103	718,733			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			233,886	233,886		233,886	(21,295)	212,591			32
33	Real Estate Taxes			7,151	7,151		7,151	(7,151)				33
34	Rent-Facility & Grounds			5,199	5,199		5,199		5,199			34
35	Rent-Equipment & Vehicles			34,466	34,466		34,466		34,466			35
36	Other (specify):*			11,244	11,244		11,244	(11,244)				36
37	**TOTAL Ownership**			965,576	965,576		965,576	5,413	970,989			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		443,733	665,593	1,109,326		1,109,326		1,109,326			39
40	Barber and Beauty Shops			10,943	10,943		10,943		10,943			40
41	Coffee and Gift Shops			5,391	5,391		5,391		5,391			41
42	Provider Participation Fee			171,756	171,756		171,756		171,756			42
43	Other (specify):*	7,842	505	23,109	31,456		31,456	(31,456)				43
44	**TOTAL Special Cost Centers**	7,842	444,238	876,792	1,328,872		1,328,872	(31,456)	1,297,416			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,702,156	1,066,577	4,606,853	10,375,586		10,375,586	(190,810)	10,184,776			45

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,482)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,189)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	45,103	30		9
10	Interest and Other Investment Income	(21,295)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(7,900)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,182)	21		24
25	Fund Raising, Advertising and Promotional	(33,287)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(102,578)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (190,810)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (190,810)		37

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

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

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

Bethesda Rehab & Senior Care

ID# 0012229

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (9,135)	21	1
2	Jury Duty Income	(34)	10	2
3	Vending Income	(302)	02	3
4	Telephone Income	(11,969)	21	4
5	Collection Fees	(44,507)	21	5
6	Bank Service Charges	(9,267)	21	6
7	Late Fees	(10,130)	21	7
8	Marketing Salaries	(3,028)	43	8
9	Community Events	(939)	43	9
10	Marketing Expenses	(7,337)	43	10
11	Development Expenses	(14,833)	43	11
12	Adult Day Salaries	(4,814)	43	12
13	Adult Day Supplies	(505)	43	13
14	Amortization - Bond Fees	(11,244)	36	14
15	Non-Care R/E Taxes	(7,151)	33	15
16	Additional R&M	58,308	06	16
17	Capitalized R&M	(23,840)	06	17
18	PAC Dues	(973)	20	18
19	Chamber of Commerce	(225)	20	19
20	Non-Allowable Legal Fees	(653)	19	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**	(102,578)		49

Bethesda Rehab & Senior Care

ID# 0012229

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1,784)											(1,784)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,189)											(6,189)	5
6	Maintenance	34,468											34,468	6
7	Other (specify):*													7
8	**TOTAL General Services**	26,495											26,495	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)											(34)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(34)											(34)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(653)											(653)	19
20	Fees, Subscriptions & Promotions	(34,485)											(34,485)	20
21	Clerical & General Office Expenses	(148,190)											(148,190)	21
22	Employee Benefits & Payroll Taxes	(7,900)											(7,900)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	**TOTAL General Administration**	(191,228)											(191,228)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(164,767)											(164,767)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	45,103											45,103	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(21,295)											(21,295)	32
33	Real Estate Taxes	(7,151)											(7,151)	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(11,244)											(11,244)	36
37	**TOTAL Ownership**	5,413											5,413	37
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(31,456)											(31,456)	43
44	**TOTAL Special Cost Centers**	(31,456)											(31,456)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(190,810)											(190,810)	45

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
N/A		N/A		N/A		

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 347,974	Norwood Management Co		$ 347,974	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 347,974			$ 347,974	$ *	39

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Computer Services	$ 32,686	Parasol Alliance		$ 32,686	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 32,686			$ 32,686	$ *	39

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 617,082	Symbria, Inc		$ 617,082	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 617,082			$ 617,082	$ *	39

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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					Norwood Mangement Co	Chicago, IL	Management Co	1
2					Symbria, Inc	Warenville, IL	Therapy Company	2
3					Parasol Alliance	Chicago, IL	IT Support	3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Norwood Management Company
Street Address: 6016 North Nina Avenue
City / State / Zip Code: Chicago, Il 60631
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management Fees				$	$		$ 347,974	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					$	$		$ 347,974	25

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Parasol Alliance
Street Address: 5620 N. Kedvale Ave
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773)219-2220
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Computer Services	Direct			$	$		$ 32,686	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					$	$		$ 32,686	25

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Symbria, Inc.
Street Address: 28100 Torch Parkway, Suite 600
City / State / Zip Code: Warrenville, IL 60555
Phone Number: (630)413-5832
Fax Number: (630)413-5801

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct			$	$		$ 617,082	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					$	$		$ 617,082	25

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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				
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X	Construction of Skilled Unit	$35,878.45	12/15/15	$ 7,517,000	$ 7,050,464	9/2023	2.4600	$ 218,697	1
2												2
3												3
4												4
5												5
	Working Capital											
6	US Bank		X	Line of Credit	Int Only		410,000	385,823	None	Varies	15,189	6
7												7
8												8
9	TOTAL Facility Related				$35,878.45		$ 7,927,000	$ 7,436,287			$ 233,886	9
	B. Non-Facility Related*											
10	Interest Income		X								(21,295)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (21,295)	14
15	TOTALS (line 9+line14)						$ 7,927,000	$ 7,436,287			$ 212,591	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	7,004	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.	$	7,004	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

Exempt from real estate taxes - not for profit entity

	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:

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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethesda Rehab & Senior Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012229

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethesda Rehab & Senior Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012229

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,558 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

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

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

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

Apartment Buildings- 13 units
Land- Sayre Avenue (formerly rental houses)

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	78,844	1919	$ 11,392	1
2					2
3	TOTALS			$ 11,392	3

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	135		1925	1925	$ 182,722	$		$	$	$ 182,722	4
5			1955	1955	657,001		65	10,108	10,108	639,319	5
6			1991	1991	2,123,475		50	42,470	42,470	1,186,794	6
7			1997	1997	263,809					263,809	7
8											8
	Improvement Type**										
9	Various			1956	4,130		20			4,130	9
10	Various			1957	4,771		20			4,771	10
11	Various			1958	14,177		20			14,177	11
12	Various			1960	27,510		20			27,510	12
13	Various			1966	15,090		20			15,090	13
14	Various			1970	434		20			434	14
15	Various			1975	5,599		20			5,599	15
16	Various			1976	10,615		20			10,615	16
17	Various			1978	12,100		20			12,100	17
18	Various			1985	8,596		20			8,596	18
19	Various			1986	1,436,330		20			1,436,330	19
20	Various			1987	6,537		20			6,537	20
21	Various			1988	50,000		20			50,000	21
22	Various			1991	1,343,365		20			1,343,365	22
23	Various			1992	52,486		20			52,486	23
24	Various			1993	59,772		20			59,772	24
25	Various			1994	4,298		20			4,298	25
26	Various			1995	80,569		20			80,569	26
27	Various			1996	136,115		20			136,115	27
28	Various			1997	123,231		20			123,231	28
29	Various			1998	122,204		20			122,204	29
30	Various			1999	178,878		20	8,944	8,944	178,878	30
31	Various			2000	1,119,263		20	55,963	55,963	1,063,300	31
32	Various			2001	140,009		20	7,168	7,168	129,020	32
33	Various			2002	432,861		20	21,748	21,748	369,713	33
34	Various			2003	614,916		20	30,746	30,746	491,933	34
35	Various			2004	33,366		20	3,527	3,527	52,902	35
36	Various			2006	255,425		20	12,771	12,771	166,026	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Various	2007	$ 25,509	$	20	$ 1,275	$ 1,275	$ 15,305	37
38	Various	2008	3,775		20	189	189	2,076	38
39	Various	2009	124,806		20	6,240	6,240	62,403	39
40	Various	2011	138,555		20	6,944	6,944	55,553	40
41	Various	2012	208,170		20	10,409	10,409	72,860	41
42	Various	2013	43,628		20	2,181	2,181	13,088	42
43	Various	2014	234,807		20	11,740	11,740	58,702	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			673,630			(673,630)		69
70	TOTAL (lines 4 thru 69)		$ 10,298,904	$ 673,630		$ 232,423	$ (441,207)	$ 8,522,331	70

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,298,904	$ 673,630		$ 232,423	$ (441,207)	$ 8,522,331	1
2	Boiler, Replacement, Basement - West Building	2015	77,673		20	3,884	3,884	15,535	2
3	Chiller Hvac, Replacement - Roof - West Building	2015	72,273		20	3,614	3,614	14,455	3
4	Sitting And Bathing Areas	2015	52,012		20	2,601	2,601	10,402	4
5	2 North Bathroom, Re-Tile Floors, Paint/Tile/Panel Walls, New Ba	2015			20				5
6	Fixtures	2015			20				6
7	3 North Bathroom, Re-Tile Floors, Paint/Tile/Panel Walls, New Ba	2015			20				7
8	Fixtures	2015			20				8
9	3 West Bathroom, Re-Tile Floors, Paint/Tile/Panel Walls, New Bat	2015			20				9
10	Fixtures	2015			20				10
11	2 North Beauty Salon - Paint Walls, Electrical, Washing Stations	2015			20				11
12	3 North Sitting Area - Re-Tile Floors, Paint/Tile/Panel Walls, New	2015			20				12
13	Bath Fixtures, Move Walls	2015			20				13
14	Dining Room Renovation, 3 North Dining Room	2015	33,465		20	1,673	1,673	6,693	14
15	Tile Flooring, Panel/Paint Walls, Add Serving Counters & Space	2015			20				15
16	Town Square Access Hallway - Ground Floor, North Building	2015	11,776		20	589	589	2,355	16
17	Tile Flooring, Panel Walls	2015			20				17
18	Boiler Control Valves - Basement - West Building	2015	8,192		20	410	410	1,638	18
19	Valve Replace	2015			20				19
20	Plumbing - Crawl Space - North Building - Pipe Replacement	2015	3,017		20	151	151	603	20
21	Reclass Rm To Bi	2015	23,735		20	1,187	1,187	4,747	21
22	Hvac Reset Due To Power Outage - Roof Top Hvac	2015			20				22
23	Pm Post Inspection Repairs	2015			20				23
24	Repairs To Heating Unit Room W223 - 2 West	2015			20				24
25	Maintenace Contract	2015			20				25
26	Repairs, Adjustments, Cleaning Work To Hvac - Hvac Room	2015			20				26
27	Boiler Reheat Repairs - Boiler Room	2015			20				27
28	Boiler Control Repairs, Relay, Gaskets, Oil Filter - Boiler Room	2015			20				28
29	Control Valve Replacement - Third Floor Mechanical Room	2015			20				29
30	Mount, Install New Wascomat Washing Machine - Laundry Room	2015			20				30
31	Ac- Post Inspection Repairs - Out Of Freon/Relief Valve Leaking	2015			20				31
32	Roof Top Unit Hvac	2015			20				32
33	Filters Replaced On All Rtus, Belt Replaced, Compressor Repairs	2015			20				33
34	TOTAL (lines 1 thru 33)		$ 10,581,047	$ 673,630		$ 246,530	$ (427,100)	$ 8,578,760	34

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 10,581,047	$ 673,630		$ 246,530	$ (427,100)	$ 8,578,760	1
2	Roof Top Unit Hvac	2015			20				2
3	Plumbing - West Building 1St Floor	2016	3,017		20	151	151	453	3
4	Hot Water Pumps - North Building 3Rd Floor	2016	2,636		20	132	132	395	4
5	Signage Throughout The Enitre Building 2016	2016	2,852		20	143	143	428	5
6	Plumbing	2016	28,630		20	1,432	1,432	4,295	6
7	Relocation Of Duel Temp Supply Piping Replacement Going Up	2016			20				7
8	From 1 North Bldg To 2 North Bldg	2016			20				8
9	Repair Flow Issues In Piping - Blockage At 1 Center Room 101	2016			20				9
10	Replace Backpitched Pipe In Crawl Space Of North Bldg Basemer	2016			20				10
11	Cut Out 25' Of Galvanized Pipe And Replace In Garage	2016			20				11
12	Elevator Repair	2016	67,548		20	3,377	3,377	10,132	12
13	Garbage Enclosure - Code Upgrade	2017	26,851		20	1,343	1,343	2,685	13
14	Diamond Rehab Expansion-Construction, Architect, Civil	2017	6,999,629		20	349,981	349,981	699,963	14
15	Engineering, Legal, Consulting & Compliance, Foreman	2017			20				15
16	Technology Wiring	2017	17,442		20	872	872	1,744	16
17	Elevator Upgrd, North Bldg	2017	6,910		20	346	346	691	17
18	Phone System Upgrade	2017	10,751		20	538	538	1,075	18
19	Security Cameras	2017	11,212		20	561	561	1,121	19
20	Nurse Call System Upgrade	2017	7,925		20	396	396	792	20
21	Boiler, Kitchen	2017	3,208		20	160	160	321	21
22	Roof Repairs	2017	2,895		20	145	145	290	22
23	Ms Renovation - Plumbing	2018	42,829		20	2,141	2,141	2,141	23
24	Alarm Panel Installation	2018	2,688		20	134	134	134	24
25	Gazebo Roof	2018	2,700		20	135	135	135	25
26	Led Light Fixtures - 4Th Floor	2018	2,795		20	140	140	140	26
27	Fire Sprinkler System - Jockey Pump	2018	3,237		20	162	162	162	27
28	Front Walk-Way Canopy	2018	3,900		20	195	195	195	28
29	Commom Area Restroom Granite & Public Bathroom Toilets	2018	4,180		20	209	209	209	29
30	Ac Unit	2018	4,365		20	218	218	218	30
31	Plumbing Repair	2018	4,500		20	225	225	225	31
32	Conference Room Remodel - Granite Countertop	2018	6,024		20	301	301	301	32
33	Office Lighting Fixtures,Ceiling,Painting,Electrical Work	2018	4,750		20	238	238	238	33
34	TOTAL (lines 1 thru 33)		$ 17,854,520	$ 673,630		$ 610,204	$ (63,426)	$ 9,307,243	34

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 17,854,520	$ 673,630		$ 610,204	$ (63,426)	$ 9,307,243	1
2	Wall Covering - 1St Floor	2018	6,986		20	349	349	349	2
3	Front Entrance Landscaping	2018	7,045		20	352	352	352	3
4	West Elevator- Replace Tamper Switch	2018	7,160		20	358	358	358	4
5	Office/Shop-Lighting Fixtures,Ceiling,Painting,Electrical Work	2018	8,750		20	438	438	438	5
6	Hvac	2018	12,427		20	621	621	621	6
7	Tub - 1C	2018	12,810		20	641	641	641	7
8	Tub - 3Rd Floor	2018	12,810		20	641	641	641	8
9	Flooring 3Rd Floor	2018	13,204		20	660	660	660	9
10	Memory Support Unit - Tub	2018	13,279		20	664	664	664	10
11	2Nd Floor Center - Tub	2018	13,279		20	664	664	664	11
12	Unitn206 Rms/Bathrms-Ceiling,Walls,Tile,New Lighting, Electric	2018	15,165		20	758	758	758	12
13	24 Through Wall Ac Units	2018	15,640		20	782	782	782	13
14	Flooring - Hallways And Chapel	2018	15,650		20	783	783	783	14
15	Unitn201 Rms/Bathrms-Ceiling,Walls,Tile,New Lighting, Electric	2018	15,651		20	783	783	783	15
16	Flooring 1St Floor Common Areas	2018	17,263		20	863	863	863	16
17	Nurse Call And Wander Guard - 4Th Floor	2018	35,001		20	1,750	1,750	1,750	17
18	Flooring - 4Th Floor	2018	48,989		20	2,449	2,449	2,449	18
19	Memory Support Unit Reno-Rms/Bathrm Remodel, Electric Work	2018	338,156		20	16,908	16,908	16,908	19
20	Lobby - Men/Women'S Bathroom Remodeling/Toilets	2018	16,990		20	850	850	850	20
21	3Rd Flr Rms/Bathrms-Ceiling,Walls,Tile,New Lighting, Electric W	2018	221,133		20	11,057	11,057	11,057	21
22	3N - Repair Failed Motor Starter	2018	2,675		20	134	134	134	22
23	Damper Repair	2018	5,667		20	283	283	283	23
24	Repair Hot Water Boiler - Loop Leaks/Low Pressure	2018	15,498		20	775	775	775	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)		$ 18,725,749	$ 673,630		$ 653,766	$ (19,864)	$ 9,350,804	34

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 18,725,749	$ 673,630		$ 653,766	$ (19,864)	$ 9,350,804	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)		$ 18,725,749	$ 673,630		$ 653,766	$ (19,864)	$ 9,350,804	34

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									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)		$	$		$	$	$	34

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)		$	$		$	$	$	34

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 1,555,409	$	$ 48,228	$ 48,228	10	$ 1,385,798	71
72	Current Year Purchases	167,400		16,740	16,740	10	16,740	72
73	Fully Depreciated Assets	104,131				10	104,131	73
74								74
75	TOTALS	$ 1,826,940	$	$ 64,968	$ 64,968		$ 1,506,669	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 20,564,081	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 673,630	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 718,733	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 45,103	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,857,473	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	East Building Renovation- Prior - 2017	$ 1,478,812	$	$	86
87	Furnishings - 2017	6,074			87
88	Land- Sayre Avenue - 2017	1,883,678			88
89					89
90					90
91	TOTALS	$ 3,368,564	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 446,148	92
93			93
94			94
95		$ 446,148	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 Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Off-Site Document Storage				5,199			5
6								6
7	TOTAL				$ 5,199 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 34,466 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 226,051	$		$ 226,051	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			64,958			64,958	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			331,745			331,745	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				261,563		261,563	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					42,839	182,170		225,009	13
14	TOTAL			$		$ 665,593	$ 443,733		$ 1,109,326	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.

STATE OF ILLINOIS

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,034	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,177,416		3
4	Supply Inventory (priced at)	22,854		4
5	Short-Term Investments	214,500		5
6	Prepaid Insurance	24,902		6
7	Other Prepaid Expenses	46,945		7
8	Accounts Receivable (owners or related parties)	2,264,789		8
9	Other(specify): See Attached Schedule	1,673		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,767,113	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	940,000		13
14	Buildings, at Historical Cost	2,927,879		14
15	Leasehold Improvements, at Historical Cost	8,797,355		15
16	Equipment, at Historical Cost	690,798		16
17	Accumulated Depreciation (book methods)	(629,914)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	499,565		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,225,683	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,992,796	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 432,789	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	606,110		29
30	Accrued Salaries Payable	362,335		30
31	Accrued Taxes Payable (excluding real estate taxes)	51,975		31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,004		32
33	Accrued Interest Payable	32,202		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,089,089		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,581,504	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,830,177		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,277,304		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,107,481	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,688,985	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,303,811	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,992,796	$	48

*(See instructions.)

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,928,707	1
2	Restatements (describe):		2
3	**Late Journal Entries**	314,381	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,243,088	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,939,277)	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	( )	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)**	$ (1,939,277)	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)**	$ 7,303,811	24 *

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

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,226,357	1
2	Discounts and Allowances for all Levels	(3,715,897)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,510,460	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,336,234	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,336,234	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	1,396	12
13	Barber and Beauty Care	11,465	13
14	Non-Patient Meals	1,482	14
15	Telephone, Television and Radio	11,969	15
16	Rental of Facility Space		16
17	Sale of Drugs	268,797	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,465	19
20	Radiology and X-Ray	10,346	20
21	Other Medical Services	228,685	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 551,605	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,295	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,295	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	16,715	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,715	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,436,309	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,925,150	31
32	Health Care	3,736,553	32
33	General Administration	2,419,435	33
	B. Capital Expense		
34	Ownership	965,576	34
	C. Ancillary Expense		
35	Special Cost Centers	1,157,116	35
36	Provider Participation Fee	171,756	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,375,586	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,939,277)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,939,277)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,451,715	44
45	Private Pay - Net Inpatient Revenue	2,283,189	45
46	Medicare - Net Inpatient Revenue	1,245,571	46
47	Other-(specify) Respite, Memory Support	483,593	47
48	Other-(specify) Managed Care (BC), Insurance	1,046,392	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,510,460	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 Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,063	1,520	$ 70,500	$ 46.38	1
2	Assistant Director of Nursing	1,819	2,058	78,391	38.09	2
3	Registered Nurses	32,278	35,688	1,081,647	30.31	3
4	Licensed Practical Nurses	15,238	16,549	459,244	27.75	4
5	CNAs & Orderlies	83,256	91,379	1,379,036	15.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,864	2,080	49,813	23.95	9
10	Activity Assistants	6,268	6,927	112,045	16.18	10
11	Social Service Workers	6,859	7,881	193,951	24.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,689	6,669	119,570	17.93	14
15	Cook Helpers/Assistants	18,418	20,419	251,753	12.33	15
16	Dishwashers					16
17	Maintenance Workers	8,103	8,894	171,381	19.27	17
18	Housekeepers	14,003	15,576	194,272	12.47	18
19	Laundry					19
20	Administrator	1,928	2,160	91,185	42.22	20
21	Assistant Administrator					21
22	Other Administrative	2,612	2,981	221,527	74.31	22
23	Office Manager					23
24	Clerical	5,796	6,642	172,500	25.97	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	1,816	2,327	47,499	20.41	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	523	566	7,842	13.86	33
34	TOTAL (lines 1 - 33)	207,533	230,316	$ 4,702,156 *	$ 20.42	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 215,637	01-03	35
36	Medical Director	64	8,038	09-03	36
37	Medical Records Consultant	17	846	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Per Chart	6,893	10-03	39
40	Physical Therapy Consultant	Monthly	111	10a-03	40
41	Occupational Therapy Consultant	Monthly	77	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	920	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Chaplain	Monthly	12,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	81	$ 244,522		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	129	$ 7,566	10-03	50
51	Licensed Practical Nurses	1,451	67,452	10-03	51
52	Certified Nurse Assistants/Aides	810	22,067	10-03	52
53	TOTAL (lines 50 - 52)	2,390	$ 97,085		53

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Erin Conley	Administrator	0	$ 91,185
Julie Boggess	CEO	0	168,463
Monica Winkelman	Executive Director	0	53,064
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 312,712

B. Administrative - Other

Description	Amount
Norwood Management Company - Management Fees	$ 347,974
TOTAL (agree to Schedule V, line 17, col. 3)	$ 347,974
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 36,544
BKD LLP	Accounting	760
Berens - Tate Consulting	Business Mngmt Consultant	1,000
ADP	Payroll Processing	33,123
See Attached	Legal	22,277
On Shift	Worforce Management	4,828
Symbia Analytics	Quality Improvement	332
Kestra Advisory Services	Benefits Consulting	6,561
Consulting Actuarial Group	401k Consulting	2,600
CCC Technologies	IT Support	19,108
Ability Network	Data Processing	11,440
See Supplemental Schedule		62,325
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 200,898

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,604
Unemployment Compensation Insurance	
FICA Taxes	339,991
Employee Health Insurance	353,034
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Incentive & Recognition	19,833
401K Plan	65,027
Life Insurance	6,064
Other Benefits	2,075
TOTAL (agree to Schedule V, line 22, col.8)	$ 907,628

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,273
Health Care Worker Background Check	
(Indicate # of checks performed 269)	6,559
Patient Background Checks 310	3,100
Licenses & Dues	3,405
Dues & Subscriptions	14,262
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,599

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	17,481
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,481

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Bethesda Rehab & Senior Care # 0012229 Report Period Beginning: 01/01/18 Ending: 12/31/18

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. **Leading Age - $6,951**

(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. $ **94,449** 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. $ **171,756**
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? **Yes** Indicate the amount. $ **1,482**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
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? N/A
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? **In Process**
Firm Name: **Marcum LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.