		FOR BHF USE					

LL1

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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0048934

Facility Name: Bethany Rehab HCC

Address: 3298 Resource Prkwy (Number) Dekalb (City) 60115 (Zip Code)

County: Dekalb

Telephone Number: (815) 756-5526 **Fax #** (815) 756-6399

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Kevin Wellen, CPA **Telephone Number:** (314) 925-4300
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 1/1/2020 to 12/31/2020 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) (Date)
(Print Name and Title) Kevin Wellen, CPA, Director
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Ave, Suite 1800, St. Louis, MO 63101
(Telephone) (314) 925-4300 Fax # (314) 925-4350

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 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	90	Skilled (SNF)	90	32,940	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,940	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	10,128	5,288	9,861	25,277	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,128	5,288	9,861	25,277	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.74%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 1/28/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/28/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 90 and days of care provided 6,495

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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		9,256	570,970	580,226		580,226		580,226			1
2	Food Purchase		13,337		13,337		13,337		13,337			2
3	Housekeeping		15,058	110,471	125,529		125,529		125,529			3
4	Laundry		20,744	73,833	94,577		94,577		94,577			4
5	Heat and Other Utilities			103,178	103,178		103,178		103,178			5
6	Maintenance	90,958	18,053	122,787	231,798		231,798		231,798			6
7	Other (specify):*											7
8	**TOTAL General Services**	90,958	76,448	981,239	1,148,645		1,148,645		1,148,645			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,480,656	188,439	27,509	2,696,604		2,696,604	(15,000)	2,681,604			10
10a	Therapy											10a
11	Activities	95,261	8,796	4,283	108,340		108,340		108,340			11
12	Social Services	114,282	125	2,825	117,232		117,232		117,232			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,690,199	197,360	46,617	2,934,176		2,934,176	(15,000)	2,919,176			16
	C. General Administration											
17	Administrative	112,609		410,446	523,055		523,055	(10,370)	512,685			17
18	Directors Fees											18
19	Professional Services			142,240	142,240		142,240	(39,932)	102,308			19
20	Dues, Fees, Subscriptions & Promotions			18,821	18,821		18,821	(2,124)	16,697			20
21	Clerical & General Office Expenses	176,181	37,087	155,842	369,110		369,110	(88,770)	280,340			21
22	Employee Benefits & Payroll Taxes			406,812	406,812		406,812		406,812			22
23	Inservice Training & Education			2,242	2,242		2,242		2,242			23
24	Travel and Seminar			896	896		896		896			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			119,297	119,297		119,297		119,297			26
27	Other (specify):*											27
28	**TOTAL General Administration**	288,790	37,087	1,256,596	1,582,473		1,582,473	(141,196)	1,441,277			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,069,947	310,895	2,284,452	5,665,294		5,665,294	(156,196)	5,509,098			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bethany Rehab HCC #0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			22,520	22,520		22,520	125,756	148,276			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			839	839		839	113,120	113,959			32
33	Real Estate Taxes			125,950	125,950		125,950		125,950			33
34	Rent-Facility & Grounds			1,139,303	1,139,303		1,139,303	(1,139,303)				34
35	Rent-Equipment & Vehicles			26,860	26,860		26,860		26,860			35
36	Other (specify):* Mortgage Insurance Premium							19,465	19,465			36
37	**TOTAL Ownership**			1,315,472	1,315,472		1,315,472	(880,962)	434,510			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		543,342	1,026,863	1,570,205		1,570,205		1,570,205			39
40	Barber and Beauty Shops			347	347		347		347			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,418	163,418		163,418		163,418			42
43	Other (specify):* Marketing	60,583		34,111	94,694		94,694	(94,694)				43
44	**TOTAL Special Cost Centers**	60,583	543,342	1,224,739	1,828,664		1,828,664	(94,694)	1,733,970			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,130,530	854,237	4,824,663	8,809,430		8,809,430	(1,131,852)	7,677,578			45

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(108)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment	(15,041)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,052)	21		24
25	Fund Raising, Advertising and Promotional	(29,528)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(67,537)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (166,696)		$	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)	(965,156)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (965,156)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,131,852)		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

Bethany Rehab HCC

ID# 0048934

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying Dues	$ (1,692)	20	1
2	PAC Dues	(432)	20	2
3	Marketing Salaries	(60,583)	43	3
4	Marketing Benefits	(4,583)	43	4
5	Miscellaneous Income	(247)	21	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
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27				27
28				28
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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**	(67,537)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(15,000)	0	0	0	0	0	0	0	0	(15,000)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	(15,000)	0	0	0	0	0	0	0	0	(15,000)	16
	C. General Administration													
17	Administrative	0	0	(10,370)	0	0	0	0	0	0	0	0	(10,370)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,616	(52,548)	0	0	0	0	0	0	0	0	(39,932)	19
20	Fees, Subscriptions & Promotions	(2,124)	0	0	0	0	0	0	0	0	0	0	(2,124)	20
21	Clerical & General Office Expenses	(69,770)	0	(19,000)	0	0	0	0	0	0	0	0	(88,770)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(71,894)	12,616	(81,918)	0	0	0	0	0	0	0	0	(141,196)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,894)	12,616	(96,918)	0	0	0	0	0	0	0	0	(156,196)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethany Rehab HCC **#** 0048934 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	121,929	3,827	0	0	0	0	0	0	0	0	125,756	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(108)	114,067	(839)	0	0	0	0	0	0	0	0	113,120	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,139,303)	0	0	0	0	0	0	0	0	0	(1,139,303)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	19,465	0	0	0	0	0	0	0	0	0	19,465	36
37	**TOTAL Ownership**	(108)	(883,842)	2,988	0	0	0	0	0	0	0	0	(880,962)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(94,694)	0	0	0	0	0	0	0	0	0	0	(94,694)	43
44	**TOTAL Special Cost Centers**	(94,694)	0	0	0	0	0	0	0	0	0	0	(94,694)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(166,696)	(871,226)	(93,930)	0	0	0	0	0	0	0	0	(1,131,852)	45

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
1	V	34	Rent	$ 1,139,303	Dekalb Health Enterprises	100.00%	$	$ (1,139,303)	1
2	V	32	Interest		Dekalb Health Enterprises	100.00%	110,879	110,879	2
3	V	19	Administrative		Dekalb Health Enterprises	100.00%	12,616	12,616	3
4	V	36	Mortgage Insurance Premium		Dekalb Health Enterprises	100.00%	19,465	19,465	4
5	V	30	Depreciation		Dekalb Health Enterprises	100.00%	121,929	121,929	5
6	V	32	Amortizaation of Financing Costs		Dekalb Health Enterprises	100.00%	3,188	3,188	6
7	V	33	Real Estate Taxes	125,950	Dekalb Health Enterprises	100.00%	125,950		7
8	V	26	Insurance	12,220	Dekalb Health Enterprises	100.00%	12,220		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,277,473			$ 406,247	$ * (871,226)	14

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	22	Insurance	$ 2,945	CarePlus Health Plus		$ 2,945	$	15
16	V	22	Insurance	78,302	Cost Plus Insurance		78,302		16
17	V	26	Insurance	104,408	LTC Plus Insurance, Inc.		104,408		17
18	V	17	Management-Operating	410,446	Tutera Health Care Service		400,076	(10,370)	18
19	V	19	Management-Data Processing	52,548	Tutera Health Care Service			(52,548)	19
20	V	30	Management-Depreciation		Tutera Health Care Service		3,827	3,827	20
21	V	10	Management-Clinical Director Fee	15,000	Tutera Health Care Service			(15,000)	21
22	V	21	Management-Accounting Mgr Fee	19,000	Tutera Health Care Service			(19,000)	22
23	V	32	Interest	839	Tutera Group, Inc			(839)	23
24	V								24
25	V	1	Dietary Equipment Rental	508	Walnut Creek Management Company, LLC		508		25
26	V	24	Travel & Seminar	860	Walnut Creek Management Company, LLC		860		26
27	V	43	Marketing	903	Walnut Creek Management Company, LLC		903		27
28	V	23	Inservice Training	242	Walnut Creek Management Company, LLC		242		28
29	V	19	Purchased Svs	8,663	Walnut Creek Management Company, LLC		8,663		29
30	V	20	Help Wanted Ads & Licenses	2,702	Walnut Creek Management Company, LLC		2,702		30
31	V	21	Supplies, Sm Equip, Postage	7,496	Walnut Creek Management Company, LLC		7,496		31
32	V	11	Activities - Supplies	49	Walnut Creek Management Company, LLC		49		32
33	V	21	Employment Expense	2,232	Critical Care Rx, LLC		2,232		33
34	V	10	Pharmacy Consultant	7,470	Critical Care Rx, LLC		7,470		34
35	V	39	Drugs	318,060	Critical Care Rx, LLC		318,060		35
36	V	39	IV Therapy & Supplies	65,663	Critical Care Rx, LLC		65,663		36
37	V	39	Medical Supplies	965	Critical Care Rx, LLC		965		37
38	V								38
39	Total			$ 1,099,301			$ 1,005,371	$ * (93,930)	39

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	JCT 6.1.98 Rev Trust	50%	Windsor Rehab & Health Care Center	Terrell, TX	The Atriums Senior Liv	Overland Park, KS	IL/AL	1
2	CMM 09 IDG Trust	16.67%	Auburn Rehab & Health Care Center	Auburn, IL	Carnegie Village Senior	Belton, MO	IL/AL	2
3	MMC 09 IDG Trust	16.67%	Carlinville Rehab & Health Care Center	Carlinville, IL	Continua Home Health	Kansas City, MO	Home Health	3
4	JCT 2009 IDG	16.66%	Coulterville Rehab & Health Care Center	Coulterville, IL	Country Gardens Asst	Muskogee, OK	AL	4
5			Crystal Pines Rehab & Health Care Center	Crystal Lake, IL	Lamar Court Assisted I	Overland Park, KS	AL	5
6			Dixon Rehab & Health Care Center	Dixon, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Fair Oaks Rehab & Health Care Center	South Beloit, IL	Rose Estates Assisted L	Overland Park, KS	AL	7
8			Hamilton Memorial Rehab & Health Care Center	McLeansboro, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Highland Rehab & Health Care Center	Kansas City, MO	Victory Hills Senior Liv	Kansas City, MO	IL/AL	9
10			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Wesley Court Assisted	Boling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Asst. Liv.	Laurinburg, NC	AL	11
12			Matton Rehab & Health Care Center	Mattoon Il	Missiona Chateua Senio	Prairie Village, KS	AL/IL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Tiffany Springs SLC	Kansas City, MO	AL/IL	13
14			Metropolis Rehab & Health Care Center	Metropolis, IL				14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LC	Kansas City, MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Ser	Kansas City, MO	Mgmt Company	16
17			Charlton Place Rehab & Health Care Center	Deatsville, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Westridge Gardens Rehab & Health Care Center	Raytown, MO	Walnut Creek Mgmt C	Kansas City, MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New Eng	Kansas City, MO	Mgmt Company	19
20			St. Paul's Senior Community	Belleville, IL	LTC Plus Insurance In	Kansas City, MO	Insurance Company	20
21			Moweaqua Rehab & Health Care Center	Moweaqua, IL	Tutera Investments, LL	Kansas City, MO	Mgmt Company	21
22			Stratford Rehab & Health Care Center	Overland Park, KS	Tutera Group, Inc.	Kansas City, MO	Mgmt Company	22
23			Carnegie Village Rehab & Health Care Center	Belton, MO	JCT Capital, Inc.	Kansas City, MO	Mgmt Company	23
24			Tiffany Springs Rehab & Health Care Center	Kansas City, MO	IPM, Inc.	Kansas City, MO	Property Mgt	24
25			Northland Rehab & Health Care Center	Kansas City, MO				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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

	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 Fee- Operating	Direct Costs	287,210,821	71	$ 15,078,459	$ 10,830,799	7,620,569	$ 400,077	1
2	30	Management Fee- Depreciation	Direct Costs	287,210,821	71	144,230		7,620,569	3,827	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					$ 15,222,689	$ 10,830,799		$ 403,904	25

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage			$ 3,983,210	$ 3,780,199			$ 110,879	1
2	Interest Income Offset										(108)	2
3	Amortize Financing Costs		X								3,188	3
4												4
5												5
	Working Capital											
6												6
7	Tutera Group, Inc	X		Note Payable			375,000			0.0100	839	7
8	Offset Related Party Interest										(839)	8
9	TOTAL Facility Related						$ 4,358,210	$ 3,780,199			$ 113,959	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,358,210	$ 3,780,199			$ 113,959	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 19,465 Line # 36

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

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 125,950	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.)		$ 125,466	2
3. Under or (over) accrual (line 2 minus line 1).		$ (484)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 126,434	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.		$ 125,950	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	117,868	8
	2016	123,522	9
	2017	124,903	10
	2018	123,481	11
	2019	125,466	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethany Rehab HCC COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0048934

CONTACT PERSON REGARDING THIS REPORT Kiley Brooks

TELEPHONE (816) 444-0900 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-01-357-010	Long-Term Care	$ 120,565.40	$ 120,565.40
2.	08-01-357-011	Long-Term Care	$ 4,900.76	$ 4,900.76
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 125,466.16	$ 125,466.16

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,866 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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).

None

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	Long-Term Care	18,866	1997	$ 303,887	1
2					2
3	TOTALS	18,866		$ 303,887	3

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	90		1997	1997	$ 3,401,350	$ 85,034	40	$ 85,034	$	$ 2,005,491	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2009 Improvements (Bethany)			2009	4,929		5			4,929	9
10	2012 Improvements (Bethany)			2012	224,122	11,206	20	11,206		86,377	10
11	2013 Improvements (Bethany)			2013	39,433	469	7	469		25,176	11
12											12
13	Home Office Allocation					3,827		3,827			13
14											14
15	1997 Improvements (Dekalb Enterprises)			1997	47,040	37	Various	37		46,438	15
16	1998 Improvements (Dekalb Enterprises)			1998	9,464		Various			9,464	16
17	1999 Improvements (Dekalb Enterprises)			1999	16,507		Various			16,507	17
18	2000 Improvements (Dekalb Enterprises)			2000	6,556		Various			6,556	18
19	2001 Improvements (Dekalb Enterprises)			2001	19,579		Various			19,579	19
20	2002 Improvements (Dekalb Enterprises)			2002	7,353		Various			7,353	20
21	2003 Improvements (Dekalb Enterprises)			2003	15,479	151	Various	151		15,052	21
22	2004 Improvements (Dekalb Enterprises)			2004	13,069		Various			13,069	22
23	2006 Improvements (Dekalb Enterprises)			2006	2,715		Various			2,715	23
24	2009 Improvements (Dekalb Enterprises)			2009	39,720	508	Various	508		37,359	24
25	2010 Improvements (Dekalb Enterprises)			2010	9,899	370	Various	370		9,146	25
26	2011 Improvements (Dekalb Enterprises)			2011	52,999	770	Various	770		52,421	26
27	2012 Improvements (Dekalb Enterprises)			2012	364,493	9,112	Various	9,112		75,177	27
28	Roof Top AC Unit (Dekalb Enterprises)			2014	8,238	824	10	824		5,286	28
29	Hallway Painting - Entire Facility (Dekalb Enterprises)			2015	40,615	2,708	15	2,708		14,667	29
30	Vinyl Tile & Cover Base - All Halls (Dekalb Enterprises)			2015	17,603	2,515	7	2,515		13,622	30
31	Ridge Cap Repalcement (Dekalb Enterprises)			2017	8,325	833	10	833		3,261	31
32	Parking Lot Improvements (Dekalb Enterprises)			2017	13,913	1,739	8	1,739		6,812	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,363,401	$ 120,103		$ 120,103	$	$ 2,476,457	70

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 254,406	$ 24,800	$ 24,800	$	Various	$ 113,204	71
72	Current Year Purchases	37,675	3,045	3,045		Various	3,045	72
73	Fully Depreciated Assets	506,936	328	328		Various	506,936	73
74								74
75	TOTALS	$ 799,017	$ 28,173	$ 28,173	$		$ 623,185	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	Patient Transport	2008 Passenger Ford E350	2008	$ 45,874	$	$	$	4	$ 45,874	76
77										77
78										78
79										79
80	TOTALS			$ 45,874	$	$	$		$ 45,874	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,512,179	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 148,276	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 148,276	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,145,516	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	WIP - Reserves	$ 12,533	92
93			93
94			94
95		$ 12,533	95

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

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 26,860 Description: Copier, dishwaser, laundry, plant, housekeeping (see WTB)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V39-03	hrs	$	5,010	$ 382,357	$	5,010	$ 382,357	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		1,311	98,799		1,311	98,799	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		5,295	381,382	1,179	5,295	382,561	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-02	# of prescrpts				316,565		316,565	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See WTB	V39-02,03				164,325	225,598		389,923	13
14	TOTAL			$	11,616	$ 1,026,863	$ 543,342	11,616	$ 1,570,205	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 800,123	$ 819,550	1
2	Cash-Patient Deposits	17,189	17,189	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 120,867)	487,842	487,842	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	123,060	127,163	6
7	Other Prepaid Expenses	427,056	441,199	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	618,297	794,190	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,473,567	$ 2,687,133	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		303,887	13
14	Buildings, at Historical Cost	268,484	4,363,401	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	197,928	844,891	16
17	Accumulated Depreciation (book methods)	(194,609)	(3,145,516)	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 (spe **Other Fixed Assets**	37,479	(853,639)	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 309,282	$ 1,513,024	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,782,849	$ 4,200,157	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,552,780	$ 1,554,215	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,335	23,335	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	219,507	219,507	30
31	Accrued Taxes Payable (excluding real estate taxes)	60,438	60,438	31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,434	32
33	Accrued Interest Payable		9,135	33
34	Deferred Compensation	856,667	856,667	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,712,727	$ 2,849,731	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,780,199	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Rent Payable		(827,247)	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,952,952	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,712,727	$ 5,802,683	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 70,122	$ (1,602,526)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,782,849	$ 4,200,157	48

***(See instructions.)**

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 44,538	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 44,538	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	25,584	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)**	$ 25,584	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)**	$ 70,122	24 *

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

Facility Name & ID Number Bethany Rehab HCC # 0048934 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 5,936,453	1
2	Discounts and Allowances for all Levels	(3,593,747)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,342,706	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,952,784	6
7	Oxygen	6,032	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,958,816	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(2,012)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	620,802	17
18	Sale of Supplies to Non-Patients	77,764	18
19	Laboratory		19
20	Radiology and X-Ray	37,353	20
21	Other Medical Services	189,822	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 923,729	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	108	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 108	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	247	28
28a	COVID-19 PHE Funding	609,408	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 609,655	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,835,014	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,148,645	31
32	Health Care	2,934,176	32
33	General Administration	1,582,473	33
	B. Capital Expense		
34	Ownership	1,315,472	34
	C. Ancillary Expense		
35	Special Cost Centers	1,665,246	35
36	Provider Participation Fee	163,418	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,809,430	40
41	**Income before Income Taxes (line 30 minus line 40)****	25,584	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 25,584	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,879,321	44
45	Private Pay - Net Inpatient Revenue	1,112,574	45
46	Medicare - Net Inpatient Revenue	(361,053)	46
47	Other-(specify) Managed Care	(501,916)	47
48	Other-(specify) Hospice	213,780	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,342,706	49

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

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

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

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

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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	1,880	2,080	$ 108,326	$ 52.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,302	30,679	1,007,722	32.85	3
4	Licensed Practical Nurses	11,296	11,924	368,963	30.94	4
5	CNAs & Orderlies	60,033	61,948	937,137	15.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,195	2,415	38,200	15.82	9
10	Activity Assistants	4,403	4,591	57,061	12.43	10
11	Social Service Workers	5,219	6,396	114,282	17.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,103	4,479	90,958	20.31	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,896	2,080	112,609	54.14	20
21	Assistant Administrator					21
22	Other Administrative	947	1,065	16,503	15.50	22
23	Office Manager					23
24	Clerical	8,317	8,644	176,181	20.38	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	2,172	2,336	42,005	17.98	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	2,389	1,966	60,583	30.82	33
34	TOTAL (lines 1 - 33)	133,152	140,603	$ 3,130,530 *	$ 22.27	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	$ 15,054	V01-3	35
36	Medical Director	Monthly	12,000	V09-5	36
37	Medical Records Consultant	Monthly	1,645	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,470	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,120	V11-3	44
45	Social Service Consultant	Monthly	2,825	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 42,114		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brian Thor	Administrator	0	$ 112,609
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 112,609

B. Administrative - Other

Description	Amount
Tutera Health Care Services - Management Fees	$ 410,446
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 410,446

C. Professional Services

Vendor/Payee	Type	Amount
Legal Accruals	Legal Services	$ 26,250
Daniel Maher Law Offices	Legal Services	1,600
Heyl Royster Voelker & Allen	Legal Services	7,631
CliftonLarsonAllen LLP	Taxes/Cost Reports	7,595
Walnut Creek Mgmt Co LLC	Data Processing	59,848
Ability Network Inc	Data Processing	418
PointClickCare Technologies Inc	Data Processing	22,256
Providigm LLC	Data Processing	7,387
Allscripts Healthcare LLC	Professional Services	2,553
Pinnacle Quailty Insight	Professional Services	436
Property Valuation Services	Professional Services	200
Walnut Creek Mgmt Co LLC	Professional Services	6,066
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 142,240

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,614
Unemployment Compensation Insurance	
FICA Taxes	257,612
Employee Health Insurance	81,249
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	4,337
TOTAL (agree to Schedule V, line 22, col.8)	$ 406,812

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,887
Health Care Worker Background Check	345
(Indicate # of checks performed 33)	
IHCA PAC	432
IL Health Care Association	6,156
DeKalb County Hlth Dept	750
Other Dues & Subscriptions	2,639
Other Licenses	622
Less: Public Relations Expense	(2,124)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,697

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	896
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 896

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Health Care Association $6,156**

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,008** 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. $ **163,418**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
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? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.