

		FOR BHF USE						

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: <u>0048934</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Bethany Rehab HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</u> to <u>12/31/2025</u> 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.																									
Address: <u>3298 Resource Parkwy</u> <u>Dekalb</u> <u>60115</u> Number City Zip Code																											
County: <u>Dekalb</u>																											
Telephone Number: <u>(815) 756-5526</u> Fax # <u>(815) 756-6399</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>1/28/1998</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Type of Ownership:																											
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other	_____	Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Signing Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Ste. 1800, St. Louis, MO 63101</u> (Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																									
☐ Charitable Corp.	☐ Individual	☐ State																									
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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: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4300</u> Email Address: _____																											

STATE OF ILLINOIS

Page 2

Facility Name & ID NumberBethany Rehab HCC# 0048934Report Period Beginning: 1/1/2025Ending: 12/31/2025

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	Medicaid Primary	Medicare Primary	Private Pay	Medicare Part A Only	Other	Total	
8	SNF	3,539	4,194	7,993		4,184	1,957	3,973	25,840	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,539	4,194	7,993		4,184	1,957	3,973	25,840	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

78.66%

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 certified beds.

number of certified beds 90

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: 12/31/2025 Fiscal Year: 12/31/2025

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

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					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	377,175	40,055	49,578	466,808		466,808	(2,239)	464,569		1
2	Food Purchase		269,150		269,150		269,150		269,150		2
3	Housekeeping		16,183	149,615	165,798		165,798		165,798		3
4	Laundry		625	114,214	114,839		114,839		114,839		4
5	Heat and Other Utilities			151,067	151,067		151,067		151,067		5
6	Maintenance	90,825	36,820	144,930	272,575		272,575		272,575		6
7	Other (specify):*										7
8	TOTAL General Services	468,000	362,833	609,404	1,440,237		1,440,237	(2,239)	1,437,998		8
	B. Health Care and Programs										
9	Medical Director			16,500	16,500		16,500		16,500		9
10	Nursing and Medical Records	2,228,070	133,022	1,662,663	4,023,755		4,023,755		4,023,755		10
10a	Therapy										10a
11	Activities	39,079	3,869	59,529	102,477		102,477		102,477		11
12	Social Services	93,472		3,380	96,852		96,852		96,852		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,360,621	136,891	1,742,072	4,239,584		4,239,584		4,239,584		16
	C. General Administration										
17	Administrative	135,739		405,971	541,710		541,710	41,289	582,999		17
18	Directors Fees										18
19	Professional Services			142,672	142,672		142,672	(46,794)	95,878		19
20	Dues, Fees, Subscriptions & Promotions			37,377	37,377		37,377	(3,785)	33,592		20
21	Clerical & General Office Expenses	204,634	25,716	561,099	791,449		791,449	(446,444)	345,005		21
22	Employee Benefits & Payroll Taxes			341,987	341,987		341,987		341,987		22
23	Inservic Training & Education			2,879	2,879		2,879		2,879		23
24	Travel and Seminar			58,956	58,956		58,956		58,956		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			90,213	90,213		90,213		90,213		26
27	Other (specify):*										27
28	TOTAL General Administration	340,373	25,716	1,641,154	2,007,243		2,007,243	(455,734)	1,551,509		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,168,994	525,440	3,992,630	7,687,064		7,687,064	(457,973)	7,229,091		29

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			61,990	61,990		61,990	145,283	207,273		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			33,101	33,101		33,101	71,450	104,551		32
33	Real Estate Taxes			88,773	88,773		88,773		88,773		33
34	Rent-Facility & Grounds			328,740	328,740		328,740	(328,740)			34
35	Rent-Equipment & Vehicles			7,755	7,755		7,755		7,755		35
36	Other (specify):* Mortgage Ins							16,857	16,857		36
37	TOTAL Ownership			520,359	520,359		520,359	(95,150)	425,209		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		48,666	923,981	972,647		972,647		972,647		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			528,195	528,195		528,195		528,195		42
43	Other (specify):* Marketing			78,448	78,448		78,448	(78,448)			43
44	TOTAL Special Cost Centers		48,666	1,530,624	1,579,290		1,579,290	(78,448)	1,500,842		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,168,994	574,106	6,043,613	9,786,713		9,786,713	(631,571)	9,155,142		45

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,239)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(323)	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	(29,925)	21		18
19	Entertainment				19
20	Contributions	(316)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(463,295)	21		24
25	Fund Raising, Advertising and Promotional	(23,949)	43		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule	5,103			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (514,944)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(116,627)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (116,627)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (631,571)		37

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

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

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

Bethany Rehab HCC

ID# 0048934

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Political Action Committee Payments	\$ (3,785)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Misc. Income	8,888	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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43				43
44				44
45				45
46				46
47				47
48				48
49	Total	5,103		49

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 Ownership-1		See PG6 - Supp		See PG6 - Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to 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	\$ 328,740	Dekalb Health Enterprises	100.00%	\$	\$ (328,740)	1
2	V	32	Interest		Dekalb Health Enterprises	100.00%	94,906	94,906	2
3	V	19	Administrative		Dekalb Health Enterprises	100.00%	11,895	11,895	3
4	V	36	Mortgage Insurance Premium		Dekalb Health Enterprises	100.00%	16,857	16,857	4
5	V	30	Depreciation		Dekalb Health Enterprises	100.00%	131,343	131,343	5
6	V	32	Amortization of Financing Costs		Dekalb Health Enterprises	100.00%	9,968	9,968	6
7	V	33	Real Estate Taxes	88,773	Dekalb Health Enterprises	100.00%	88,773		7
8	V	26	Insurance	18,159	Dekalb Health Enterprises	100.00%	18,159		8
9	V	21	Taxes		Dekalb Health Enterprises	100.00%	38,204	38,204	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 435,672			\$ 410,105	\$ * (25,567)	14

* Total must agree with the amount recorded on line 34 of Schedule V1

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	17 Management-Operating	\$ 405,971	Tutera Health Care Service		\$ 447,260	\$ 41,289	15
16	V	19 Management-Data Processing	58,689	Tutera Health Care Service			(58,689)	16
17	V	30 Management-Depreciation		Tutera Health Care Service		13,940	13,940	17
18	V	43 Management-Marketing	54,499	Tutera Health Care Service			(54,499)	18
19	V	32 Interest	33,101	Tutera Investments			(33,101)	19
20	V	26 Insurance	69,515	LTC Plus Insurance, Inc.		69,515		20
21	V	10 Pharmacy Consultant	7,300	Critical Care Rx, LLC		7,300		21
22	V	39 Supplies & Non-Covered Drugs	5,960	Critical Care Rx, LLC		5,960		22
23	V	39 Drugs	216,899	Critical Care Rx, LLC		216,899		23
24	V	39 OTC drugs	(56)	Critical Care Rx, LLC		(56)		24
25	V	10 Nursing Purchased Svcs	79,041	TeamWorkers, LLC		79,041		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		\$ 930,919			\$ 839,859	\$ * (91,060)	39

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

Report Period Beginning:

Ending:

ID#

0048934

1/1/2025

12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	Place of Residence		Operator/Licensee	Building Co.	Management
	Ownership		Ownership	Co. /Home Office	Ownership
	First Name	M.I.	Last Name	City	State
	Percentage			Percentage	Percentage
76					
77					
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VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Carlinsville Rehab & Health Care Center	Carlinsville, IL			Antioch Valley	Overland Park, KS	AL	1
2	Carnegie Village Rehab & Health Care Center	Belton, MO			Carnegie Village Senior	Belton, MO	IL/AL	2
3	Charlton Place Rehab & Health Care Center	Deatsville, AL			Country Gardens Assisted	Muskogee, OK	AL	3
4	Coulterville Rehab & Health Care Center	Coulterville, IL			Laurel Assisted Living	Liberty, MO	AL	4
5	Crystal Pines Rehab & Health Care Center	Crystal Lake, IL			Missiona Chateau Senior	Prairie Village, KS	AL/IL	5
6	Dixon Rehab & Health Care Center	Dixon, IL			Oakley Court Assisted	Freeport, IL	AL	6
7	Estoria Rehabilitation	Liberty, MO			Town Center	Overland Park, KS	AL	7
8	Fair Oaks Rehab & Health Care Center	South Beloit, IL			Stratford Commons Memory	Overland Park, KS	Memory Care	8
9	Grand Meadows Senior Living	Asbury, IA			The Lodge at Manito	Manito, IL	AL	9
10	Highland Rehab & Health Care Center	Kansas City, MO			Tiffany Springs SLC	Kansas City, MO	AL/IL	10
11	Hillsboro Rehab & Health Care Center	Hillsboro, IL			Wesley Court Assisted	Boling Springs, SC	AL	11
12	Lakeland Rehab & Health Care Center	Effingham, IL						12
13	Matton Rehab & Health Care Center	Mattoon IL						13
14	Meridian Rehab & Health Care Center	Wichita, KS						14
15	Metropolis Rehab & Health Care Center	Metropolis, IL			LTC Plus Insurance LLC	Kansas City, MO	Insurance Company	15
16	Monterey Park Rehab & Health Care Center	Independence, MO			JCT Capital, Inc.	Kansas City, MO	Mgmt Company	16
17	Montgomery Children's Specialty Center	Montgomery, AL			Tutera Group, Inc.	Kansas City, MO	Mgmt Company	17
18	Moweaqua Rehab & Health Care Center	Moweaqua, IL			Tutera Health Care Services	Kansas City, MO	Mgmt Company	18
19	Northland Rehab & Health Care Center	Kansas City, MO			Tutera Investments, LLC	Kansas City, MO	Mgmt Company	19
20	St. Paul's Senior Community	Belleville, IL			Walnut Creek Mgmt Co	Kansas City, MO	Mgmt Company	20
21	Stratford Rehab & Health Care Center	Overland Park, KS			Walnut Creek New Era	Kansas City, MO	Mgmt Company	21
22	The Village at Mission	Prairie Village, KS			IPM, Inc.	Kansas City, MO	Property Mgt	22
23	Tiffany Springs Rehab & Health Care Center	Kansas City, MO			Columbia 7611 LLC	Kansas City, MO	Building Company	23
24	Westview of Derby Rehab & Health Care Center	Derby, KS			JCT FLP Auburn LLC	Aurora, IL	Building Company	24
25	Windsor Estates of St. Charles	St. Charles, MO			TeamWorkers LLC	Kansas City, MO	Agency Nursing	25
26	Holly Hill Rehab & Health Care Center	Sulphur, LA			Critical Care Rx, LLC	Kansas City, MO	Pharmacy Company	26
27	Rosewood Rehab & Health Care Center	Lake Charles, LA						27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

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☒XNO☐

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

Name of Related OrganizationTutera Health Care Services
Street Address7611 State Line Road
City / State / Zip CodeKansas City, Missouri 64114
Phone Number(816) 444-0900
Fax Number(816) 822-0081

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Management Fee Operating	Direct Cost	512,439,158	114	\$ 24,349,098	\$ 16,637,381	9,412,889	\$ 447,264	1
2	30	Management Fee Depreciation	Direct Cost	512,439,158	114	758,922		9,412,889	13,940	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					\$ 25,108,020	\$ 16,637,381		\$ 461,204	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		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	HUD (Landlord WTB)		X	Mortgage			\$	3,983,210	\$	3,218,107						\$	94,906		1	
2	Interest Income Offset																(323)		2	
3	Amortize Financing Costs		X														9,968		3	
4																			4	
5																			5	
	Working Capital																			
6	Tutera Group Inc.	X		Working Capital				2,521,944		4,479,800							37,378		6	
7	Interest Exp Offset - RP																(37,378)		7	
8																			8	
9	TOTAL Facility Related							\$	6,505,154	\$	7,697,907					\$	104,551		9	
	B. Non-Facility Related*																			
10																			10	
11																			11	
12																			12	
13																			13	
14	TOTAL Non-Facility Related							\$		\$						\$			14	
15	TOTALS (line 9+line14)							\$	6,505,154	\$	7,697,907					\$	104,551		15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 16,857 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.		\$	124,438	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.)		\$	106,605	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(17,833)	3	
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	106,606	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.		\$	88,773	7	
Assessed Value from Real Estate Tax Bill:	2024	126,911	8		
Real Estate Tax Bill for Calendar Year:	2020	128,000	9		
	2021	129,566	10		
	2022	122,400	11		
	2023	118,738	12		
	2024	106,605	13		
				14	FOR BHF USE ONLY
				14	FROM R. E. TAX STATEMENT FOR 2024 \$
				15	PLUS APPEAL COST FROM LINE 5 \$
				16	LESS REFUND FROM LINE 6 \$
				17	AMOUNT TO USE FOR RATE CALCULATION\$

- 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.

2024 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 2024 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 2024.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	08-01-357-010	Long-Term Care	\$ 102,075.16	\$ 102,075.16
2.	08-01-357-011	Long-Term Care	\$ 4,530.24	\$ 4,530.24
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 106,605.40	\$ 106,605.40

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,866

B. General Construction Type: Exterior BrickFrame Brick

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

No

J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Long-Term Care	18,866		1997		\$ 303,887	
2							
3	TOTALS	18,866				\$ 303,887	

XL OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	90		1997	1997	\$ 3,401,350	\$ 85,034	40	\$ 85,034		\$ 2,430,660	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2009 Improvements (Bethany)		2009		4,929					4,929	9
10	2012 Improvements (Bethany)		2012		224,122	10,872		10,872		142,240	10
11	2013 Improvements (Bethany)		2013		39,433	2,028		2,028		26,190	11
12	Concrete replacementsa ground sewer lids		2021		6,185	412		412		1,959	12
13	2025 Improvements		2025		6,800	708		708		708	13
14	Building Paintings		2024		8,750	1,750		1,750		1,896	14
15	1997 Improvements (Dekalb Enterprises)		1997		47,040	37		37		46,622	15
16	1998 Improvements (Dekalb Enterprises)		1998		9,464					9,464	16
17	1999 Improvements (Dekalb Enterprises)		1999		16,507					16,507	17
18	2000 Improvements (Dekalb Enterprises)		2000		6,556					6,556	18
19	2001 Improvements (Dekalb Enterprises)		2001		19,579					19,579	19
20	2002 Improvements (Dekalb Enterprises)		2002		7,353					7,353	20
21	2003 Improvements (Dekalb Enterprises)		2003		15,479					15,479	21
22	2004 Improvements (Dekalb Enterprises)		2004		13,069					13,069	22
23	2006 Improvements (Dekalb Enterprises)		2006		2,715					2,715	23
24	2009 Improvements (Dekalb Enterprises)		2009		39,720					39,720	24
25	2010 Improvements (Dekalb Enterprises)		2010		9,899					9,899	25
26	2011 Improvements (Dekalb Enterprises)		2011		52,999					52,999	26
27	2012 Improvements (Dekalb Enterprises)		2012		364,493	9,112		9,112		120,738	27
28	2014 Improvements (Dekalb Enterprises)		2014		8,238					8,238	28
29	2015 Improvements (Dekalb Enterprises)		2015		58,219	2,708		2,708		45,809	29
30	2017 Improvements (Dekalb Enterprises)		2017		22,238					22,238	30
31											31
32	Exhaust Fan Installation (Dekalb Enterprise)		2022		8,000	800		800		2,667	32
33											33
34	Home Office Allocation					13,940		13,940			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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Laundry Drain Replacement (Dekalb Enterprise)	2024	\$ 21,400	\$ 476	15	\$ 476		\$ 952	37
38	Door renovation(Units 110,306) (Dekalb Enterprise)	2024	4,443	148	10	148		296	38
39	Flooring Renovation Vinyl (307,308,309) (Dekalb Enterprise)	2024	4,890	326	5	326		652	39
40	Carpet- Room 100,101,102,103 (North Hall reno Project) (Dekalb	2024	7,403	123	5	123		246	40
41	Door interior (Dekalb Enterprise)	2024	5,934	49	10	49		98	41
42	Painting- Room 100,101,102,103 (North Hall reno Project) (Dekalb	2024	7,591	90	7	90		180	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)		\$ 4,444,798	\$ 128,613		\$ 128,613	\$	\$ 3,050,658	70

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

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	\$222,794	\$61,387	\$61,387	\$		\$51,022	71
72	Current Year Purchases	69,931	7,769	7,769			7,769	72
73	Fully Depreciated Assets	839,821					839,821	73
74								74
75	TOTALS	\$1,132,546	\$69,156	\$69,156	\$		\$898,612	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	\$	\$	\$		\$45,874	76
77	Patient Transport	2019 Chrysler Pacifica + Convers	2022	47,523	9,504	9,504			34,850	77
78										78
79										79
80	TOTALS			\$93,397	\$9,504	\$9,504	\$		\$80,724	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)	\$5,974,628	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$207,273	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$207,273	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)	\$4,029,994	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	\$18,816	92
93	WIP - Reserves	47,915	93
94			94
95		\$66,731	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
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: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 7,755 Description: Copier, dishwasher, laundry, plant, housekeeping (see WTB)
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
Fiscal Year EndingAnnual Rent
12. /2026 \$
13. /2027 \$
14. /2028 \$

* 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.

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

☒ 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)	\$					

- (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

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	

- (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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	V39-03	hrs	\$		\$ 228,393	\$		\$ 228,393	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs			6,780			6,780	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-02,03	hrs			296,913	37		296,950	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 prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>					99,095			99,095	12
13	Other (specify): <u>See WTB</u>	V39-02,03				292,800	48,629		341,429	13
14	TOTAL			\$		\$ 923,981	\$ 48,666		\$ 972,647	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 59,581	\$ 112,093	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	784,962	784,962	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,402	76,791	6
7	Other Prepaid Expenses	319,198	331,529	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	60,491	252,399	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,291,634	\$ 1,557,774	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		4,154,578	14
15	Leasehold Improvements, at Historical Cost	290,219	290,219	15
16	Equipment, at Historical Cost	409,492	1,225,944	16
17	Accumulated Depreciation (book methods)	(440,529)	(4,029,994)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): WIP	91,677	91,677	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 350,859	\$ 2,036,311	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,642,493	\$ 3,594,085	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 516,324	\$ 540,953	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	75,134	75,134	28
29	Short-Term Notes Payable	4,479,800	4,479,800	29
30	Accrued Salaries Payable	239,725	239,725	30
	Accrued Taxes Payable (excluding real estate taxes)	100,064	100,064	31
32	Accrued Real Estate Taxes(Sch.IX-B)		106,606	32
33	Accrued Interest Payable		7,777	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to/from Related Party	163,968	163,968	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,575,015	\$ 5,714,027	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,927,388	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,927,388	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,575,015	\$ 8,641,415	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,932,522)	\$ (5,047,330)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,642,493	\$ 3,594,085	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,637,983)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,637,983)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,474,294)	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) Prior Year Entries	179,755	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,294,539)	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)	\$ (3,932,522)	24 *

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,555,697	1
2	Discounts and Allowances for all Levels	(2,138,988)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,416,709	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,387,770	6
7	Oxygen	8,409	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,396,179	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	2,239	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	445,560	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,454	19
20	Radiology and X-Ray	7,455	20
21	Other Medical Services	20,388	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 508,096	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	323	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 323	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Revenue	(8,888)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (8,888)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,312,419	30

2		
II. Expenses		Amount
A. Operating Expenses		
31	General Services	1,440,237
32	Health Care	4,239,584
33	General Administration	2,007,243
B. Capital Expense		
34	Ownership	520,359
C. Ancillary Expense		
35	Special Cost Centers	1,051,095
36	Provider Participation Fee	528,195
D. Other Expenses (specify):		
37		
38		
39		
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,786,713
41	Income before Income Taxes (line 30 minus line 40)**	(1,474,294)
42	Income Taxes	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,474,294)

III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 820,819.00
45	Medicaid Managed Long Term Services and Supports (MLTSS)	970,142.00
46	MMAI-Medicaid is the Primary Payer	1,849,442.00
47	MMAI-Medicare is the Primary Payer	
48	Private Pay	1,280,751.00
49	Medicare Part A	647,403.00
50	Other-(specify) Managed Care	-151,848.00
51	Other-(specify)	
52	Other-(specify)	
53	Other-(specify)	
54	Other-(specify)	
55	Other-(specify)	
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,416,709

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,578	2,717	\$ 166,338	\$ 61.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,310	9,734	485,013	49.83	3
4	Licensed Practical Nurses	11,565	12,214	544,834	44.61	4
5	CNAs & Orderlies	40,046	42,146	1,021,094	24.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	797	862	19,005	22.05	9
10	Activity Assistants	1,463	1,600	20,074	12.55	10
11	Social Service Workers	3,480	3,618	93,472	25.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,203	19,342	377,175	19.50	15
16	Dishwashers					16
17	Maintenance Workers	3,343	3,552	90,825	25.57	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,373	2,543	135,739	53.38	20
21	Assistant Administrator					21
22	Other Administrative	7	7	165	23.57	22
23	Office Manager					23
24	Clerical	7,740	8,411	204,634	24.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	680	680	10,626	15.63	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	101,585	107,426	\$ 3,168,994 *	\$ 29.50	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	417	\$ 25,028	V01-3	35
36	Medical Director	Monthly	16,500	V09-3	36
37	Medical Records Consultant	Monthly	832	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,312	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	48	3,869	V11-3	44
45	Social Service Consultant	48	2,860	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	513	\$ 59,401		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,486	\$ 487,103		50
51	Licensed Practical Nurses	11,115	655,022		51
52	Certified Nurse Assistants/Aides	12,565	470,350		52
53	TOTAL (lines 50 - 52)	30,166	\$ 1,612,475		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Scott Morton	Administrator	0	\$ 135,739	Workers' Compensation Insurance	\$	57,051	IDPH License Fee	\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	15,165
				FICA Taxes		272,815	Health Care Worker Background Check (Indicate # of checks performed)	1,014
				Employee Health Insurance		17,000	Patient Background Checks	230
				Employee Meals			Association Dues (total from pg 22, #4)	10,791
				Illinois Municipal Retirement Fund (IMRF)*			Other Licenses	9,361
				Other Benefits		(4,879)	Other Dues	816
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
B. Administrative - Other							Less: Public Relations Expense	()
Description			Amount				PAC and Lobbying payments	(3,785)
Tutera Health Care Services - Management Fee			\$ 405,971				All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Daniel Maher Law Offices	Legal Services		\$ 16,706	N/A		\$	Out-of-State Travel	\$
Aline Ops	CRM Software		1,882					
Consolidated Billing Services	Billing		398					
Walnut Creek Mgt Company	CBO, IT & DP Mgt Fee, Data p		58,689				In-State Travel	58,956
Managed Care Group	Managed Care Contracting		1,650					
Netsmart Tech	E.H.R.		2,156					
PointClickCare Tech	Medical Records Software		14,237					
Proclaim Partners	Claims Mgt		2,080				Seminar Expense	
Wellsky Corporation	Data Processing Fees		1,275					
Payroll	Payroll Processing		16,881					
CLA, LLP	Cost Report/Taxes		6,166					
Various	Data Processing/Software		20,552					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 58,956

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number

Bethany Rehab HCC

STATE OF ILLINOIS

#0048934

Report Period Beginning:1/1/2025

Ending:12/31/2025

Page 22

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union'

No

(2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below
Use the drop down list to identify the association.

Association Name

Amount

IL HEALTHCARE ASSOCIATION (IHCA)

7,006

7,006

Total

(3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1

IL HEALTHCARE ASSOCIATION (IHCA)

3,785

3,785

Total

(4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)

10,791

10,791

Total

(5)

Indicate the total amount of both disposable and non-disposable incontinent expens
and the location of this expense on Sch. V.

\$42,745

Line10

(6)

Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

Yes

If NO, attach a complete explanation.

(7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$528,195

This amount is to be recorded on line 42 of Schedule V.

(8)

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.

(9)

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

(10)

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.

(11)

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.

\$

(12)

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

(13)

Has an audit been performed by an independent certified public accounting firm

Firm Name:

N/A

No

(14)

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

Yes

(15)

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: